FY '17 TRAINING AND TRAVEL EXPENSES to DATE

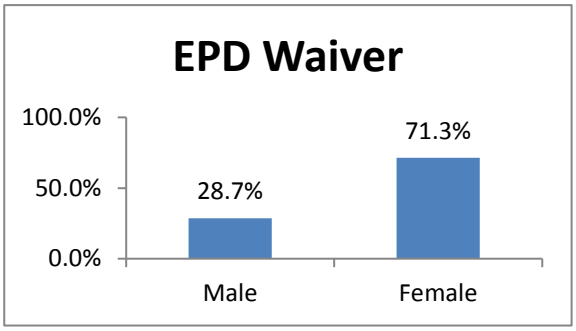
Name of Meeting/Conference/Training	Date Held	City/State	Air/train/bus costs	Hotel	Registration	Ground trans	Food	Attendee's Name	Total Costs
National Association of State Health Policy Conference (NASHP)	10/16 - 19, 2016	Pittsburgh, PA	$269.20	$530.10	$795.00	$95.00	$135.00	Trina Dutta	$1,824.30
NASHP	10/16 - 19, 2016	Pittsburgh, PA	$447.00	$331.70	$795.00		$127.50	Anthony Proctor	$1,701.20
NASHP	10/17 - 19, 2016	Pittsburgh, PA	$446.20	$353.40	$575	$50.00	$189.00	Dena Hasan	$1,613.60
NASHP	10/17 - 19, 2016	Pittsburgh, PA	$312.70	$353.40	$575.00	$50.00	$135.00	D. Groves	$1,425.60
NASHP	10/17 - 19, 2016	Pittsburgh, PA	$224.20	$353.40	$575.00	50.00	135.00	Joe Weissfeld	$1,337.60
NASHP	10/17 - 19, 2016	Pittsburgh, PA	$269.20	$331.70	795.00		127.50	Alice Weiss	$1,523.40
Obesity Task Force Meeting*	17-Oct	New York, NY	$281.00			$50.00	$55.00	C. Schlosberg	$386.00
American Medical Billing Conference	10/26 - 29, 2016	Las Vegas, Nevada	$365.20	$455.00	$699.00	$50.00	$224.00	Wanda Patterson	$1,793.20
Partnering for Cures Conference	11/13 - 15, 2016	New York, NY	$252.00	$664.80			$185.00	Lisa Fitzpatrick, MD	$1,101.80
CPT and RBRVS Annual Symposium	11/16 - 18, 2016	Chicago, IL	$404.00	$538.00	$750.00	$60.00	$185.00	Amy Xing	$1,937.00
National Association of State Medicaid Directors Conference (NAMD)	11/6 - 8, 2016	Arlington, VA			$450.00			Sumita Chaudhuri	$450.00
NAMD	11/6 - 8, 2016	Arlington, VA			$450.00			Ieisha Gray	$450.00
NAMD	11/6 - 8, 2016	Arlington, VA			$450.00			Lisa Truitt	$450.00
NAMD	11/6 - 8, 2016	Arlington, VA			$450.00			Claudia Schlosberg	$450.00
NAMD	11/6 - 8, 2016	Arlington, VA			$450.00			Alice Weiss	$450.00
NAMD	11/6 - 8, 2016	Arlington, VA			$450.00			Lisa Fitzpatrick, MD	$450.00
NAMD	11/6 - 8, 2016	Arlington, VA			$450.00			Bidemi Isiaq	$450.00
NAMD	11/6 - 8, 2016	Arlington, VA			$450.00			Carleta Belton	$450.00
NAMD	11/6 - 8, 2016	Arlington, VA			$450.00			Erin Holve	$450.00
NCHAA 2016 Annual Training Conference	11/14 - 18, 2016	Atlanta, GA	$180.20	$650.00	$0.00	$50.00	$310.50	Carl Ditchey	$1,190.70
NCHAA 2016 Annual Training Conference	11/14-18, 2016	Atlanta, GA	$205.00	$1,299.20	$950.00	$50.00	$310.50	Angela Veney	$2,814.70
Institute for Healthcare Improvement 28th Annual Conference	12/6 - 7, 2016	Orlando, FLA	$256.47	$346.50	$1,300.00		$147.50	Derdire Coleman	$2,050.47
								TOTAL	$24,749.57
***DC Treasurer will be reimbursed up to $400.00 by the BIPARTISAN POLICY CENTER for attendance and participation in this meeting**									
								Updated 12-6-2016	Page 1

This report displays enrollment data for beneficiaries with spans from Oct 1, 2015 through Se

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AN

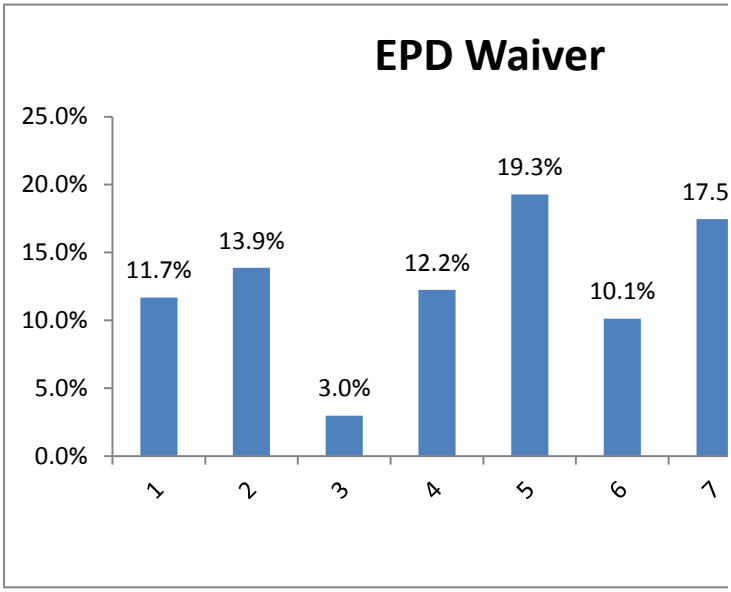
Gender	EPD Waiver
Male	934
Female	2,325
TOTAL	3,259

Gender	EPD Waiver
Male	28.7%
Female	71.3%



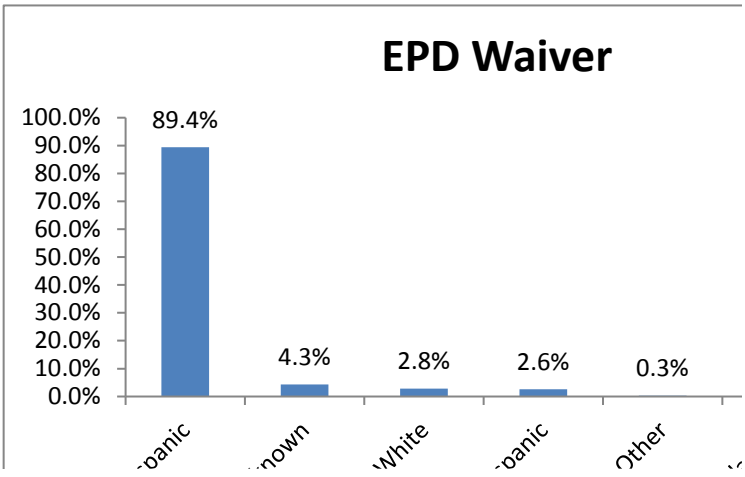
Ward	EPD Waiver
1	381
2	452
3	97
4	399
5	628
6	330
7	569
8	390
Unknown	13
TOTAL	3,259

Ward	EPD Waiver
1	11.7%
2	13.9%
3	3.0%
4	12.2%
5	19.3%
6	10.1%
7	17.5%
8	12.0%
Unknown	0.4%



Race/Ethnicity	EPD Waiver
Black, Non-Hispanic	2,912
Unknown	140
White	91
Hispanic	85
Other	9
Asian / Pacific Islander	18
American Indian	4
TOTAL	3,259

Race/Ethnicity	EPD Waiver



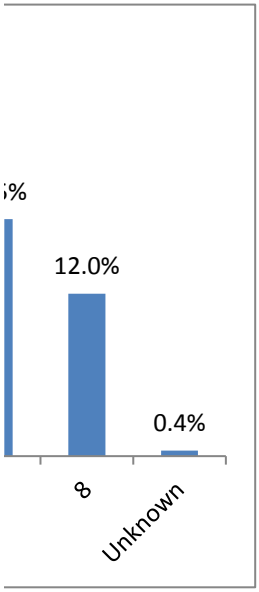
Black, Non-Hispanic	89.4%
Unknown	4.3%
White	2.8%
Hispanic	2.6%
Other	0.3%
Asian / Pacific Islander	0.6%
American Indian	0.1%

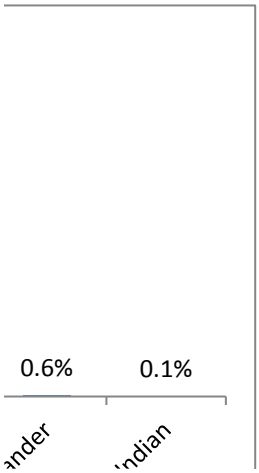
NOTES:

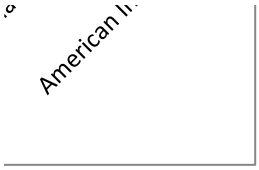
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extra

p 30, 2016.

ND RACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROL







ıcted on February 9, 2017.

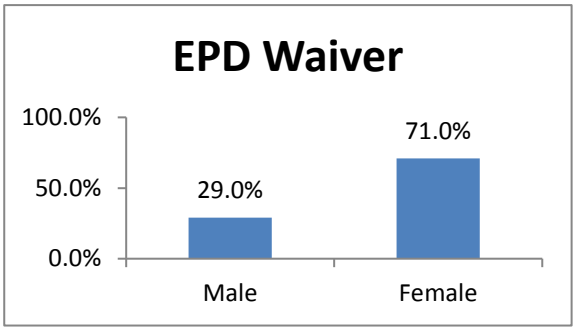
.LED DURING FY16.

This report displays enrollment data for beneficiaries with spans from Oct 1, 2016 through De

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AN

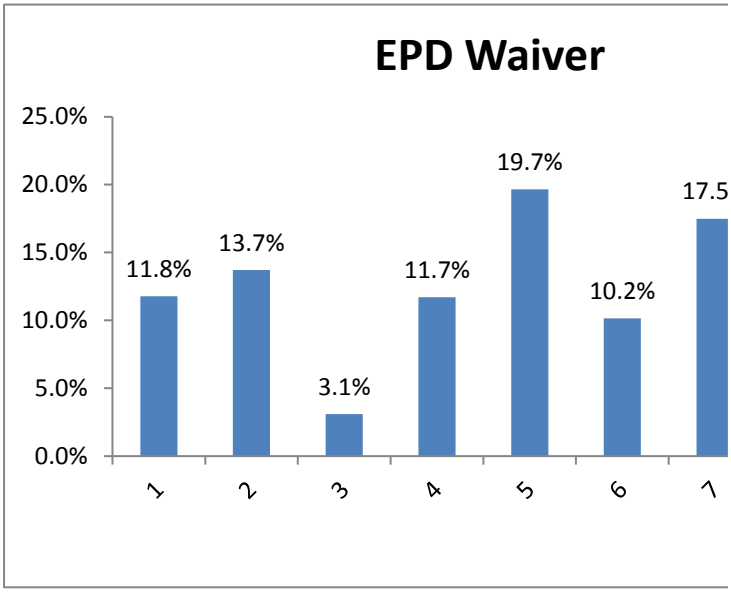
Gender	EPD Waiver
Male	843
Female	2,061
TOTAL	2,904

Gender	EPD Waiver
Male	29.0%
Female	71.0%



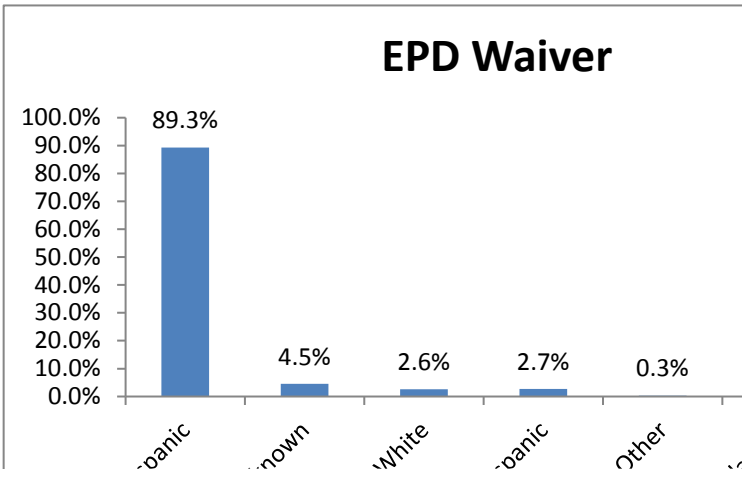
Ward	EPD Waiver
1	342
2	398
3	90
4	340
5	571
6	295
7	508
8	350
Unknown	10
TOTAL	2,904

Ward	EPD Waiver
1	11.8%
2	13.7%
3	3.1%
4	11.7%
5	19.7%
6	10.2%
7	17.5%
8	12.1%
Unknown	0.3%



Race/Ethnicity	EPD Waiver
Black, Non-Hispanic	2,592
Unknown	131
White	76
Hispanic	78
Other	8
Asian / Pacific Islander	16
American Indian	3
TOTAL	2,904

Race/Ethnicity	EPD Waiver



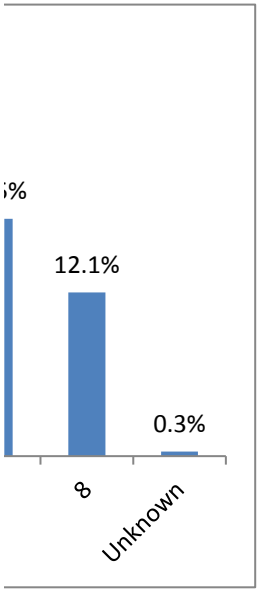
Black, Non-Hispanic	89.3%
Unknown	4.5%
White	2.6%
Hispanic	2.7%
Other	0.3%
Asian / Pacific Islander	0.6%
American Indian	0.1%

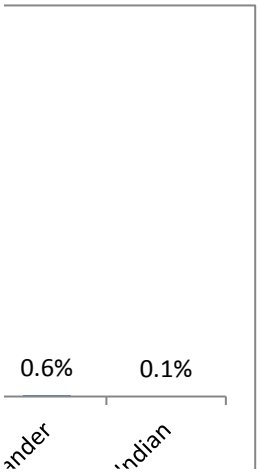
NOTES:

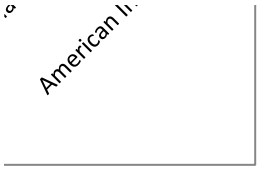
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extra

ɛc 31, 2016.

ND RACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROL







ıcted on February 9, 2017.

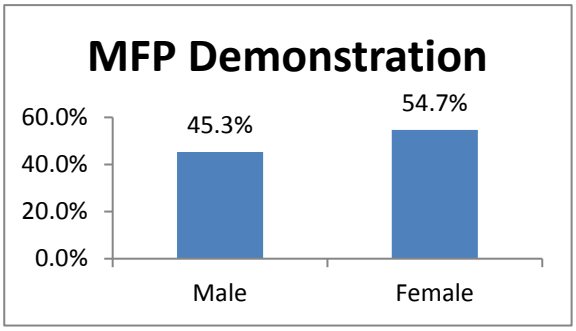
.LED DURING FY17 to date.

This report displays enrollment data for beneficiaries with spans from Oct 1, 2015 through Sep 30,

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AND F

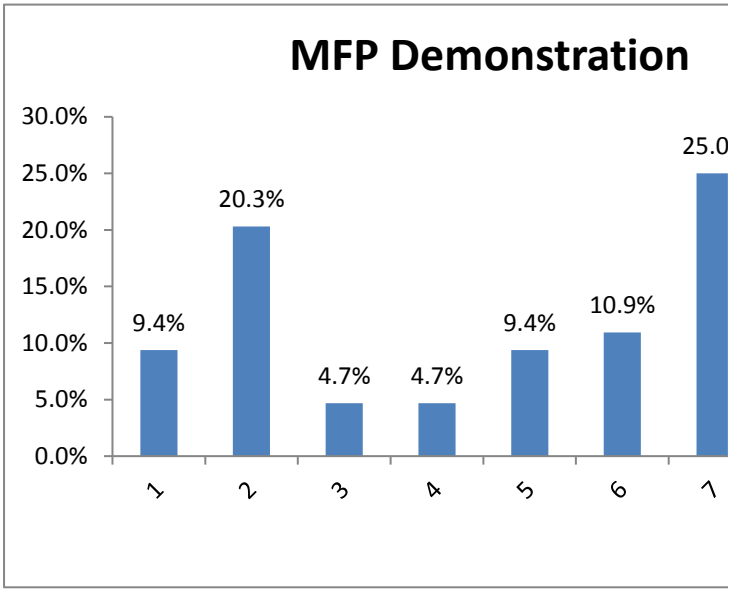
Gender	MFP Demonstration
Male	29
Female	35
TOTAL	64

Gender	MFP Demonstration
Male	45.3%
Female	54.7%



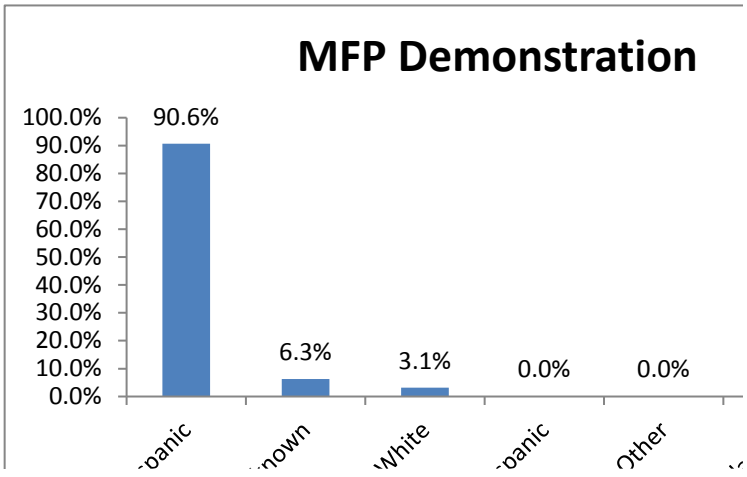
Ward	MFP Demonstration
1	6
2	13
3	3
4	3
5	6
6	7
7	16
8	9
Unknown	1
TOTAL	64

Ward	MFP Demonstration
1	9.4%
2	20.3%
3	4.7%
4	4.7%
5	9.4%
6	10.9%
7	25.0%
8	14.1%
Unknown	1.6%



Race/Ethnicity	MFP Demonstration
Black, Non-Hispanic	58
Unknown	4
White	2
Hispanic	-
Other	-
Asian / Pacific Islander	-
American Indian	-
TOTAL	64

Race/Ethnicity	MFP Demonstration



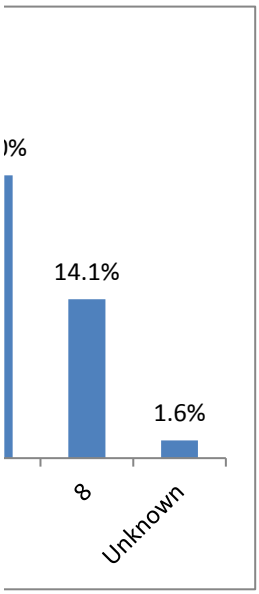
Black, Non-Hispanic	90.6%
Unknown	6.3%
White	3.1%
Hispanic	0.0%
Other	0.0%
Asian / Pacific Islander	0.0%
American Indian	0.0%

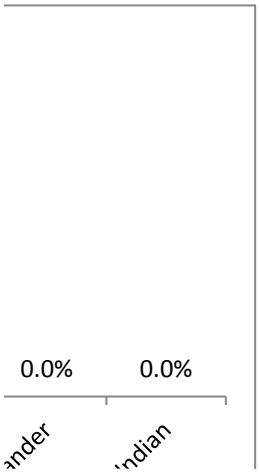
NOTES:

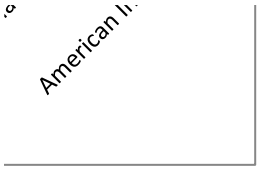
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extracted c

2016.

RACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROLLED







on February 9, 2017.

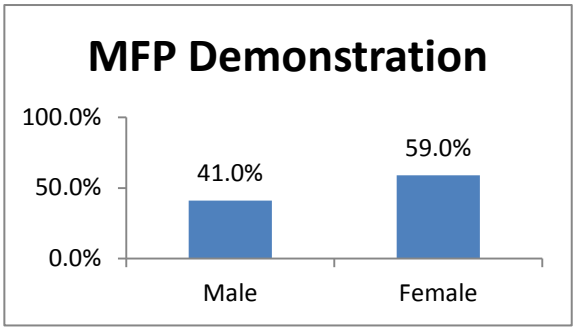
) DURING FY16.

This report displays enrollment data for beneficiaries with spans from Oct 1, 2016 through Dec 31,

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AND F

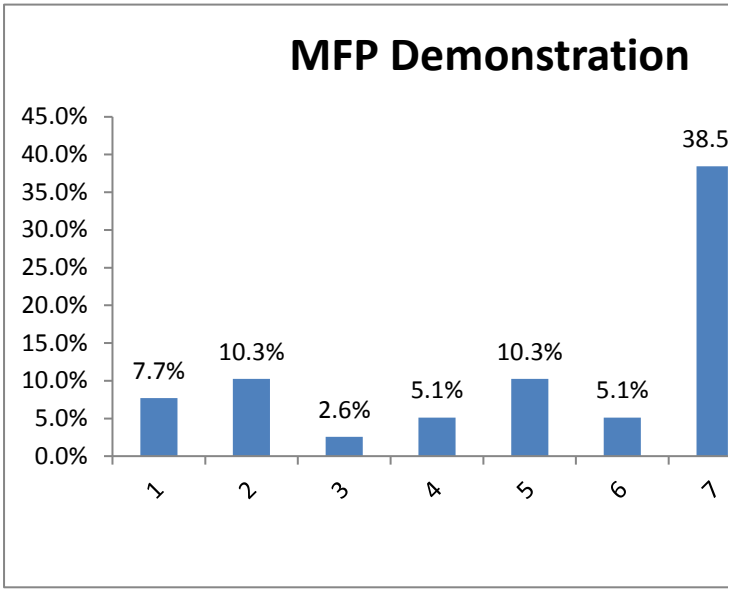
Gender	MFP Demonstration
Male	16
Female	23
TOTAL	39

Gender	MFP Demonstration
Male	41.0%
Female	59.0%



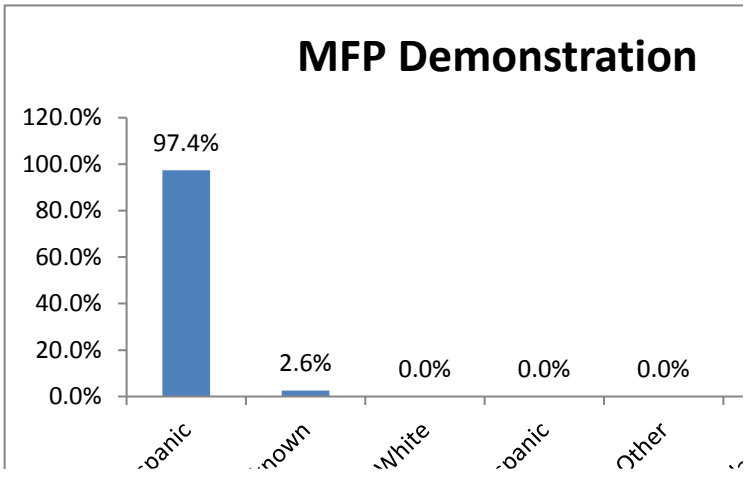
Ward	MFP Demonstration
1	3
2	4
3	1
4	2
5	4
6	2
7	15
8	6
Unknown	2
TOTAL	39

Ward	MFP Demonstration
1	7.7%
2	10.3%
3	2.6%
4	5.1%
5	10.3%
6	5.1%
7	38.5%
8	15.4%
Unknown	5.1%



Race/Ethnicity	MFP Demonstration
Black, Non-Hispanic	38
Unknown	1
White	-
Hispanic	-
Other	-
Asian / Pacific Islander	-
American Indian	-
TOTAL	39

Race/Ethnicity	MFP Demonstration



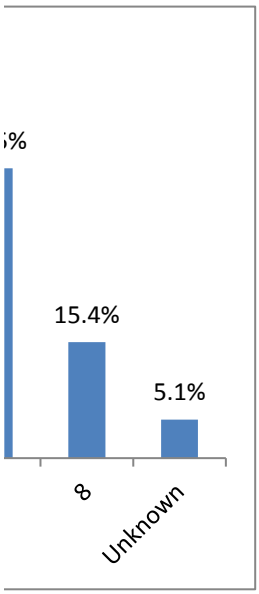
Black, Non-Hispanic	97.4%
Unknown	2.6%
White	0.0%
Hispanic	0.0%
Other	0.0%
Asian / Pacific Islander	0.0%
American Indian	0.0%

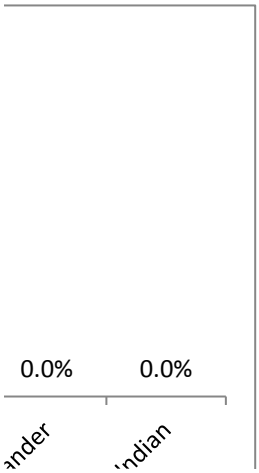
NOTES:

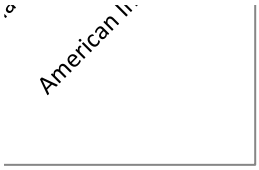
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extracted c

2016.

RACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROLLED







on February 9, 2017.

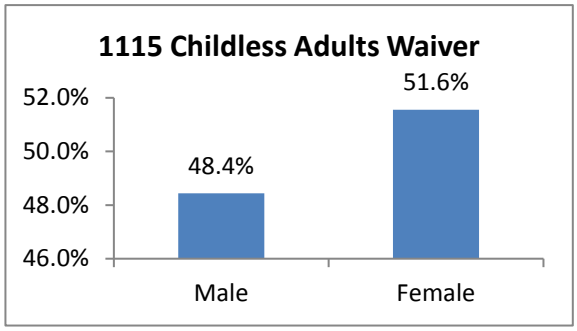
) DURING FY17 TO DATE.

This report displays enrollment data for beneficiaries with spans from Oct 1, 2016 through Dec 31

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AND

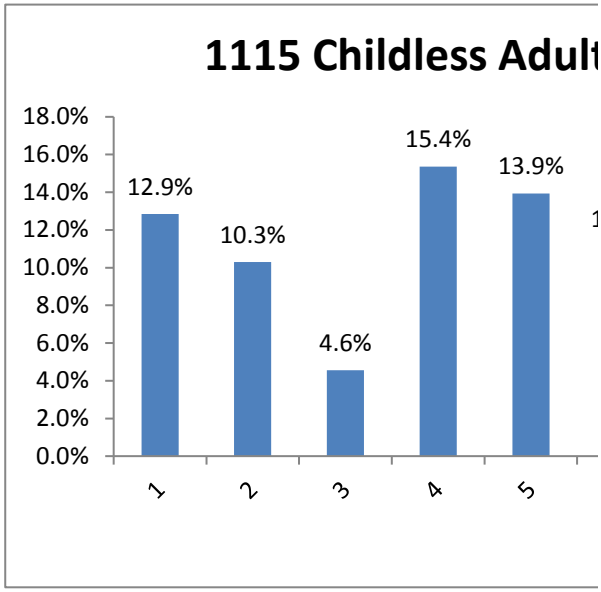
Gender	1115 Childless Adults Waiver
Male	5,608
Female	5,969
TOTAL	11,577

Gender	1115 Childless Adults Waiver
Male	48.4%
Female	51.6%



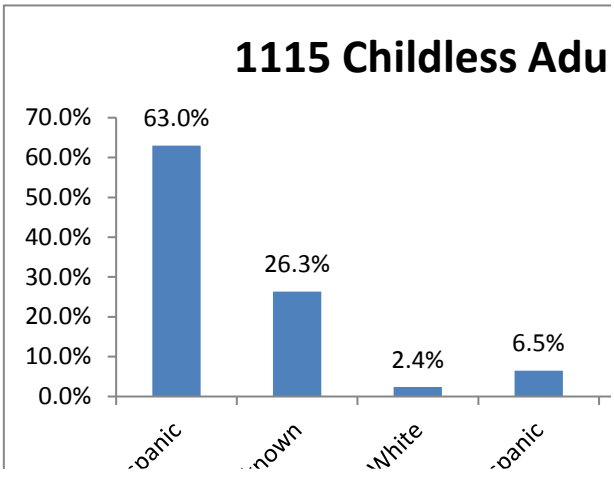
Ward	1115 Childless Adults Waiver
1	1,488
2	1,192
3	527
4	1,779
5	1,613
6	1,286
7	1,958
8	1,690
Unknown	44
TOTAL	11,577

Ward	1115 Childless Adults Waiver
1	12.9%
2	10.3%
3	4.6%
4	15.4%
5	13.9%
6	11.1%
7	16.9%
8	14.6%
Unknown	0.4%

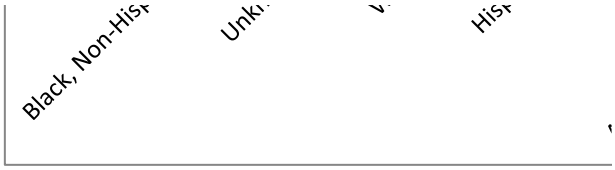


Race/Ethnicity	1115 Childless Adults Waiver
Black, Non-Hispanic	7,294
Unknown	3,047
White	277
Hispanic	753
Other	123
Asian / Pacific Islander	81
American Indian	2
TOTAL	11,577

Race/Ethnicity	1115 Childless Adults Waiver



Black, Non-Hispanic	63.0%
Unknown	26.3%
White	2.4%
Hispanic	6.5%
Other	1.1%
Asian / Pacific Islander	0.7%
American Indian	0.0%

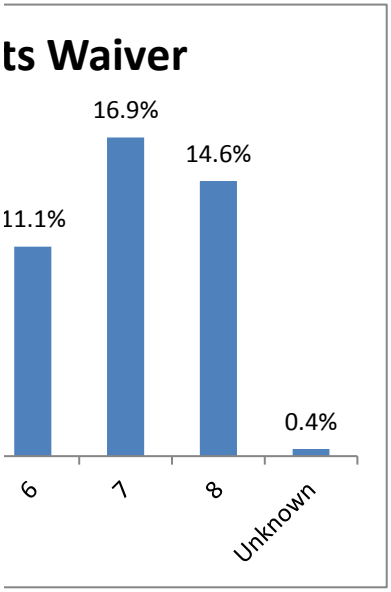


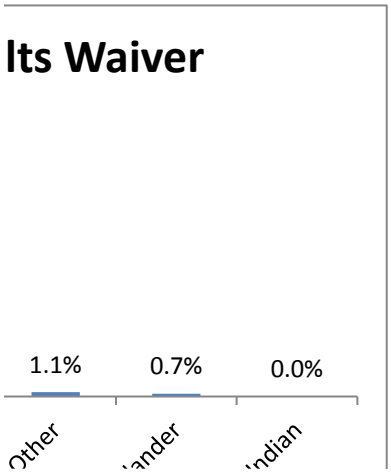
NOTES:

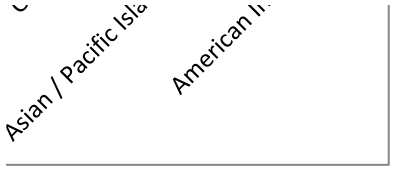
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extracted

., 2016.

RACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROLLE







on February 9, 2017.

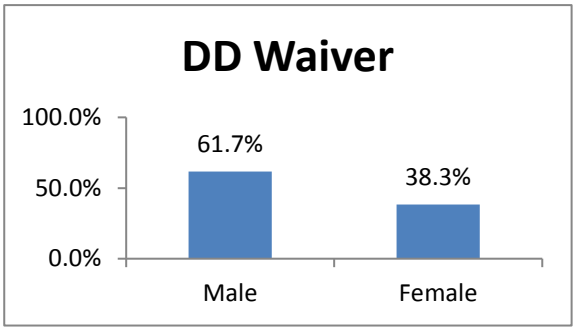
D DURING FY16Q1.

This report displays enrollment data for beneficiaries with spans from Oct 1, 2015 through Se

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AN

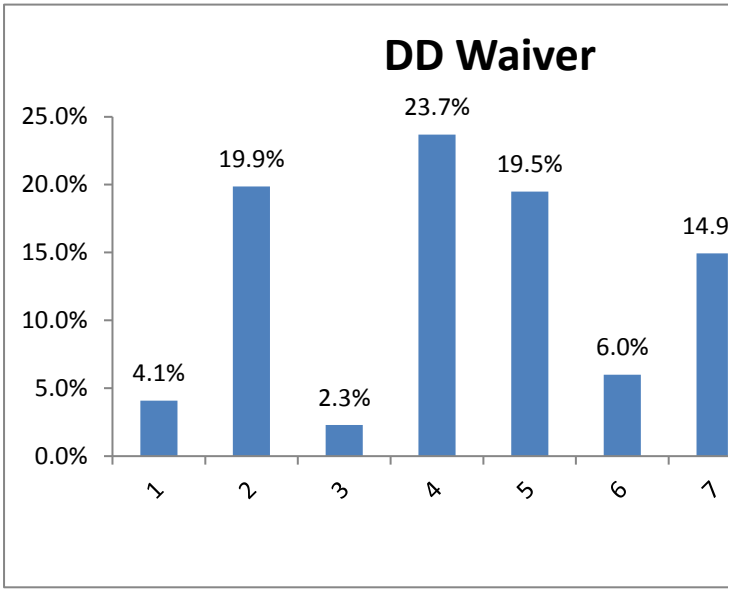
Gender	DD Waiver
Male	1,098
Female	683
TOTAL	1,781

Gender	DD Waiver
Male	61.7%
Female	38.3%



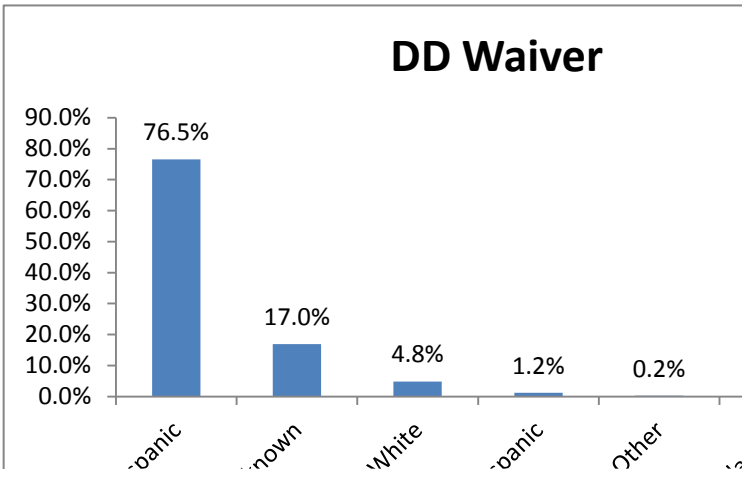
Ward	DD Waiver
1	73
2	354
3	41
4	422
5	347
6	107
7	266
8	169
Unknown	2
TOTAL	1,781

Ward	DD Waiver
1	4.1%
2	19.9%
3	2.3%
4	23.7%
5	19.5%
6	6.0%
7	14.9%
8	9.5%
Unknown	0.1%

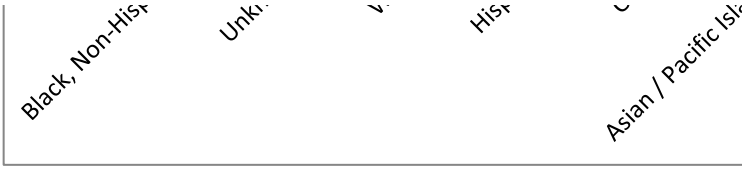


Race/Ethnicity	DD Waiver
Black, Non-Hispanic	1,363
Unknown	302
White	86
Hispanic	21
Other	4
Asian / Pacific Islander	4
American Indian	1
TOTAL	1,781

Race/Ethnicity	DD Waiver



Black, Non-Hispanic	76.5%
Unknown	17.0%
White	4.8%
Hispanic	1.2%
Other	0.2%
Asian / Pacific Islander	0.2%
American Indian	0.1%

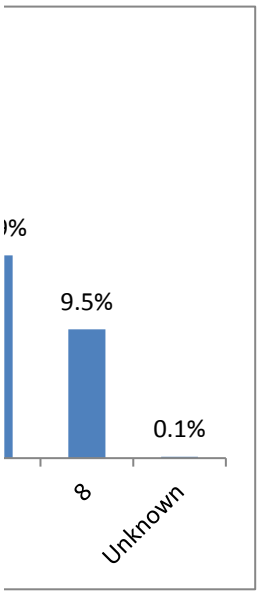


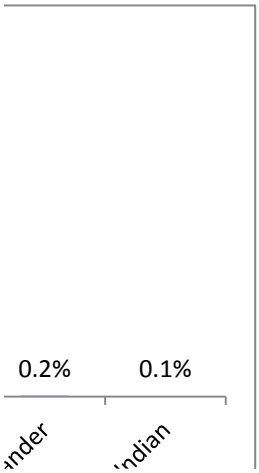
NOTES:

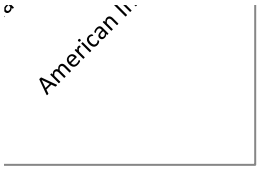
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extra

p 30, 2016.

ND RACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROL







ıcted on February 9, 2017.

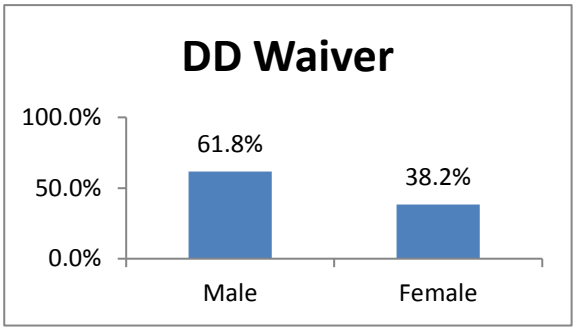
.LED DURING FY16.

This report displays enrollment data for beneficiaries with spans from Oct 1, 2016 through De

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AN

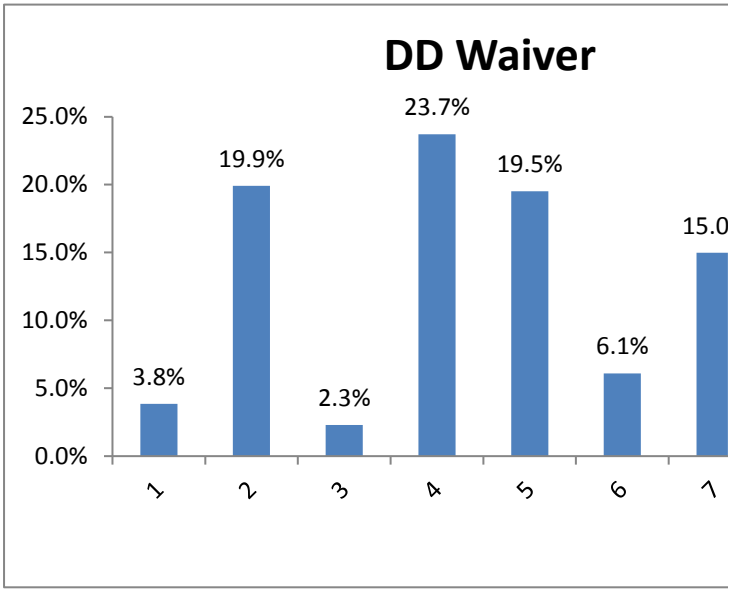
Gender	DD Waiver
Male	1,076
Female	666
TOTAL	1,742

Gender	DD Waiver
Male	61.8%
Female	38.2%



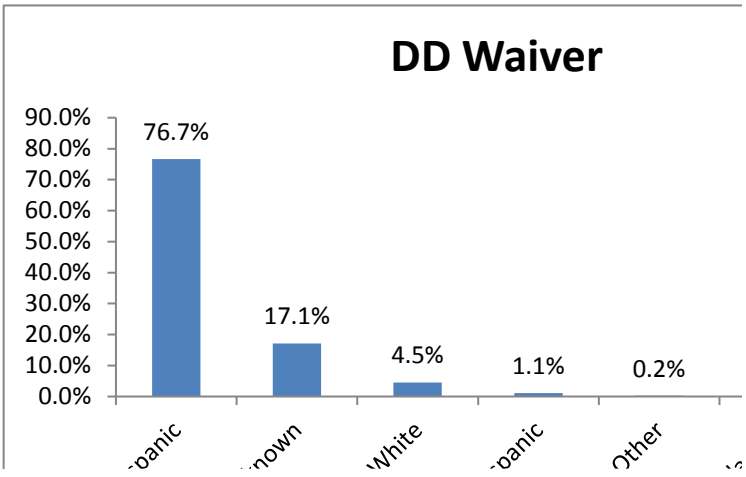
Ward	DD Waiver
1	67
2	347
3	40
4	413
5	340
6	106
7	261
8	166
Unknown	2
TOTAL	1,742

Ward	DD Waiver
1	3.8%
2	19.9%
3	2.3%
4	23.7%
5	19.5%
6	6.1%
7	15.0%
8	9.5%
Unknown	0.1%

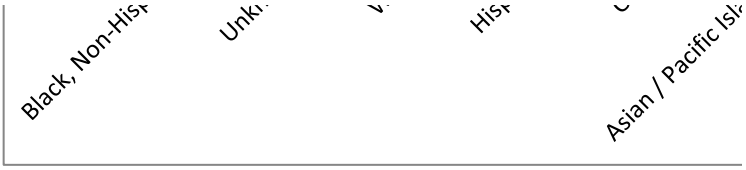


Race/Ethnicity	DD Waiver
Black, Non-Hispanic	1,336
Unknown	298
White	79
Hispanic	19
Other	4
Asian / Pacific Islander	5
American Indian	1
TOTAL	1,742

Race/Ethnicity	DD Waiver



Black, Non-Hispanic	76.7%
Unknown	17.1%
White	4.5%
Hispanic	1.1%
Other	0.2%
Asian / Pacific Islander	0.3%
American Indian	0.1%

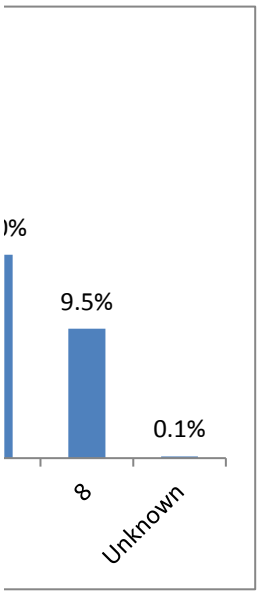


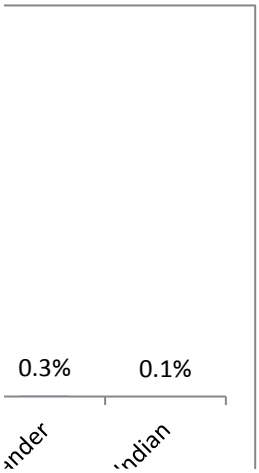
NOTES:

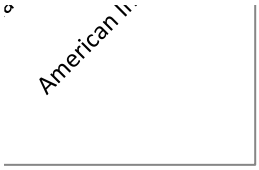
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extra

ɛc 31, 2016.

ND RACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROL







ıcted on February 9, 2017.

.LED DURING FY17 TO DATE.

Employees with Salary Over $100,000

Title	Name	Series	Grade	Step	FY16 Salary	Series	Grade
Director, Dept of Hlthcare Fin	Turnage,Wayne M	EX	11	0	$ 195,702.00	EX	11
Medical Officer	Fitzpatrick,Lisa K	DS	17	0	$ 179,717.00	DS	17
Agency Fiscal Officer	Shaffer,Darrin A	DS	16	10	$ 171,161.00	DS	16
Chief Information Officer	Sidransky,David Ira	DS	16	0	$ 166,844.56	DS	16
Senior Deputy Director	Schlosberg,Claudia	XS	11	0	$ 166,844.55	XS	11
Chief Operating Officer	Evans,Kenneth L	DS	16	0	$ 166,844.55	DS	16
Deputy Director	Chaudhuri,Sumita	DS	16	0	$ 166,844.55	DS	16
Program Manager	Holt,Maude R	DS	16	0	$ 165,394.00	DS	16
Chief of Staff	Williamson,Melanie J.	N/A	N/A	N/A	N/A	XS	10
Healthcare Program Manager	Holve,Erin	DS	16	0	$ 162,000.00	DS	16
Supvy. Healthcare Program Mgr	Shearer,Donald	DS	16	0	$ 160,630.87	DS	16
Supervisory Attorney Advisor	Johnson,Sheryl C	LX	2	0	$ 152,981.78	LX	2
Program Manager	Wilson,Gerald W	DS	16	0	$ 152,758.00	DS	16
Healthcare Program Mgr	Truitt,Lisa Ann	DS	16	0	$ 151,306.62	DS	16
Associate Director (Medicaid F	Martin,Angelique Monique	DS	15	0	$ 150,358.00	DS	15
Supvy. Healthcare Program Mgr	Weiss,Alice	DS	16	0	$ 150,000.00	DS	16
Healthcare Program Manager	Gray,Ieisha	DS	16	0	$ 148,248.00	DS	16
Accounting Officer	Kennedy,Thomas F	DS	15	7	$ 140,784.00	DS	15
Reimbursement Supervisor	Hoeflinger,Frederick	DS	15	7	$ 140,784.00	DS	15
Special Assistant	Blissett,Kai A	N/A	N/A	N/A	N/A	DS	15
Operations Manager	Bell,Melanie J	DS	14	0	$ 139,521.08	DS	14
Special Projects Officer	Dutta,Trina	DS	15	0	$ 133,900.00	DS	15
Program Manager	Sonosky,Colleen A	DS	15	0	$ 133,312.69	DS	15
Program Manager	Bishop,Cavella Denise	DS	15	0	$ 132,219.97	DS	15
Program Manager	Yancy,Constance M.	DS	15	0	$ 130,345.47	DS	15
Reimbursement Specialist	Hinsley,Patricia	DS	14	10	$ 129,592.00	DS	14
Program Analyst	Lacey,Antonio E	DS	14	10	$ 129,592.00	DS	14
Information & Privacy Officer	Payne,LaRah D	DS	14	10	$ 129,592.00	DS	14
Pharmacist	Fairfax,Charlene D	DS	14	9	$ 126,369.00	DS	14
Supervisory Program Analyst	Squires,Patricia	DS	14	0	$ 124,625.52	DS	14
Human Resources Officer II	Shorter,Portia	DS	14	0	$ 124,526.32	DS	14
Pharmacist	Amare,Gidey	DS	14	8	$ 123,146.00	DS	14

Employees with Salary Over $100,000

Program Analyst	Barton Walker,Linda D	DS	14	8	$ 123,146.00	DS	14
Pharmacist	Terry,Jonas	DS	14	8	$ 123,146.00	DS	14
Statistician	Sumner,John W	DS	14	10	$ 119,811.00	DS	14
Information Technology Spec.	Edwards,Daren M	DS	14	10	$ 119,811.00	DS	14
Program Manager	Devasia,Mary	DS	14	0	$ 117,570.86	DS	14
Management Analyst	Coleman,Derdire J	DS	14	5	$ 113,477.00	DS	14
Management Analyst	Monroe,Emilie F	DS	14	5	$ 113,477.00	DS	14
Special Projects Officer	Uzes,Yorick F	DS	14	5	$ 113,477.00	DS	14
Supervisory Management Analyst	Lewis,Danielle R.	DS	14	0	$ 116,184.00	DS	14
Chief Investigator	Ditchey,Carl J	DS	14	0	$ 114,627.70	DS	14
Compliance Monitor	Rooney,Surobhi N.	DS	14	7	$ 114,199.00	DS	14
Management Analyst	Dehaan,Kerda I	DS	14	5	$ 113,477.00	DS	14
Budget Officer	Bowes, Deon	DS	14	5	$ 113,477.00	DS	14
Project Manager	Lawrence,Katheryne	DS	14	5	$ 113,477.00	DS	14
Management Analyst	Williams,Lawrence D.	DS	14	5	$ 113,477.00	DS	14
Associate Director (Reimbursem	Isiaq,Abidemi S	DS	15	0	$ 113,300.00	DS	15
Public Affairs Specialist	White,Dorinda	DS	14	7	$ 110,874.00	DS	14
Project Manager	Groves,DaShawn A	DS	14	7	$ 110,874.00	DS	14
Reimbursement Analyst	Clark,Andrea	DS	14	7	$ 110,874.00	DS	14
Supervisory Program Analyst	Wedeles,John A.	DS	14	0	$ 110,000.00	DS	14
Program Analyst	Bell-Foxworth,Gwendolyn	DS	13	10	$ 109,665.00	DS	13
Program Analyst	Smith,Clydie A	DS	13	10	$ 109,665.00	DS	13
Managemeny Analyst	Willard,Monique Andre	DS	13	10	$ 109,665.00	DS	13
Clinical Case Worker	Johnson,Paula R	DS	13	10	$ 109,665.00	DS	13
Behavioral Health Coordinator	Nearon Jr.,Darrell M	DS	13	10	$ 109,665.00	DS	13
Program Analyst	Sutton,Pamela	DS	13	10	$ 109,665.00	DS	13
Senior Budget Analyst	Simms,James	DS	13	10	$ 109,665.00	DS	13
Program Manager	Crawley,Jennifer	DS	14	0	$ 109,448.00	DS	14
Project Manager	Sarigol,Leyla D	DS	14	6	$ 107,895.00	DS	14
Attorney Advisor	Parsons,Keith David	LA	13	6	$ 105,564.00	LA	13
Attorney Advisor	Jones,Lauren S	LA	13	6	$ 105,564.00	LA	13
Management Analyst	Hodge,Pamela Leeatta	DS	14	3	$ 107,031.00	DS	14
Senior Fraud Data Surveillance	Williams,Adrian L	DS	14	3	$ 107,031.00	DS	14
Nurse Specialist II	Smith,Loretta	DS	12	9	$ 105,098.00	DS	12

Employees with Salary Over $100,000

Project Manager	Spence-Smith,Louis	DS	14	5	$ 104,916.00	DS	14
Senior Financial Management An	Akinshemoyin,Musili T	DS	14	5	$ 104,916.00	DS	14
Reimbursement Analyst	XING,YUN	DS	14	5	$ 104,916.00	DS	14
Attorney Advisor	Hui,Irene	LA	13	5	$ 102,548.00	LA	13
Management Analyst	Fauntleroy,Elisa	DS	13	8	$ 104,207.00	DS	13
Management Analyst	Bolling,Michael D	DS	13	8	$ 104,207.00	DS	13
Clinical Case Worker	Tabb,Shirley L	DS	13	8	$ 104,207.00	DS	13
Senior Budget Analyst	Johnson,Andrea L	DS	13	8	$ 104,207.00	DS	13
Nurse Specialist I	Ehikhamenor,Betty A	DS	11	10	$ 103,431.00	DS	11
Nurse Specialist I	Bowens,Marlaina	DS	11	10	$ 103,431.00	DS	11
Nurse Specialist I	Rowe,Robbin R	DS	11	10	$ 103,431.00	DS	11
Reimbursement Analyst	Augenbaum,Sharon R.	DS	14	4	$ 101,934.00	DS	14
Nurse Specialist II	White,Francine	DS	12	8	$ 101,594.00	DS	12
Project Coordinator	Sutton,Brenda M	DS	13	7	$ 101,478.00	DS	13
Investigator	Metrey,Jon Joseph	DS	13	7	$ 101,478.00	DS	13
Project Manager	Childs,Jacqulyn S	DS	13	7	$ 101,478.00	DS	13
Project Coordinator	Wilson-Kear,Lucy	DS	13	7	$ 101,478.00	DS	13
Management Analyst	Robinson,Suprenia A	DS	13	7	$ 101,478.00	DS	13
Special Projects Officer	Chakkappan,Roopa R	DS	14	1	$ 100,585.00	DS	14
Management Liaison Specialist	Washington,Radeena P	DS	13	8	$ 99,229.00	DS	13
Management Analyst	Brown,Charlita R	DS	13	6	$ 98,749.00	DS	13
Management Analyst	Brannum Jr.,James	DS	13	6	$ 98,749.00	DS	13
Management Analyst	Thomas,Ann B	DS	13	6	$ 98,749.00	DS	13
Special Projects Coordinator	Belton,Carleta Y	DS	13	6	$ 98,749.00	DS	13
SeniorAccountant	Minocha,Shikha	DS	13	6	$ 98,749.00	DS	13

Employees with Salary Over $100,000

Step	FY17 Salary
0	$201,573.16
0	$185,108.51
10	$176,296.00
0	$171,849.90
0	$171,849.89
0	$171,849.89
0	$171,849.88
0	$170,355.82
0	$167,000.00
0	$166,860.00
0	$165,449.80
0	$163,690.51
0	$157,340.74
0	$155,845.52
0	$154,868.74
0	$154,500.00
0	$152,695.44
8	$148,900.00
8	$148,900.00
0	$143,467.00
0	$139,521.08
0	$137,917.00
0	$137,312.07
0	$136,186.57
0	$134,255.83
10	$133,480.00
10	$133,476.00
10	$133,476.00
9	$130,157.00
0	$128,364.29
0	$128,262.11
0	$126,838.00

Employees with Salary Over $100,000

8	$126,838.00
8	$126,838.00
10	$123,403.00
10	$123,403.00
10	$121,097.99
6	$120,200.00
6	$120,200.00
6	$120,200.00
0	$119,669.52
0	$118,066.53
8	$117,267.00
5	$116,881.00
5	$116,882.00
5	$116,883.00
5	$116,884.00
0	$116,699.00
7	$114,199.00
7	$114,200.00
7	$114,201.00
0	$113,300.00
10	$112,956.00
10	$112,956.00
10	$112,956.00
10	$112,956.00
10	$112,956.00
10	$112,956.00
10	$112,956.00
10	$112,953.00
0	$112,422.44
6	$111,131.00
6	$110,730.00
6	$110,730.00
3	$110,243.00
3	$110,243.00
9	$108,251.00

Employees with Salary Over $100,000

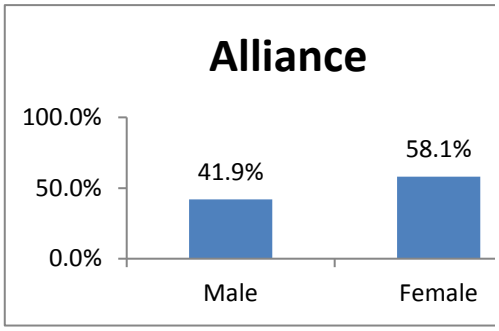
5	$108,063.00
5	$108,063.00
5	$108,063.00
5	$107,567.00
8	$107,334.00
8	$107,334.00
8	$107,334.00
8	$107,332.00
10	$106,534.00
10	$106,534.00
10	$106,534.00
4	$104,995.00
8	$104,642.00
7	$104,523.00
7	$104,523.00
7	$104,523.00
7	$104,523.00
7	$104,523.00
1	$103,605.00
9	$101,826.00
6	$101,712.00
6	$101,712.00
6	$101,712.00
6	$101,712.00
6	$101,711.00

This report displays enrollment data for beneficiaries with spans from Oct 1, 2015 through Sep 30, 2

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AND R

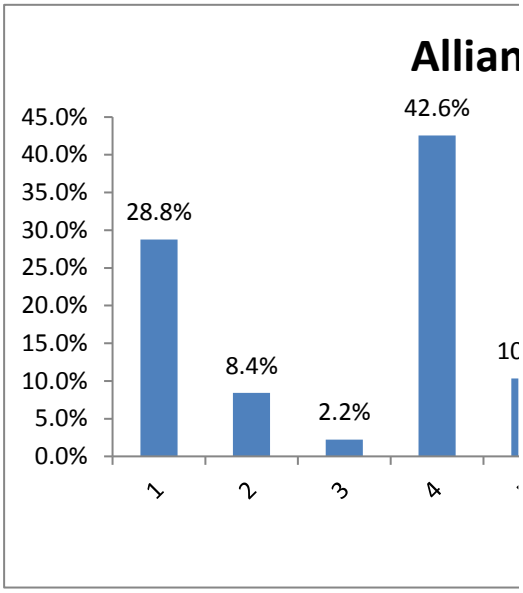
Gender	Alliance	Medicaid FFS	Medicaid MCO
Male	8,956	34,708	115,525
Female	12,411	33,711	102,752
TOTAL	21,367	68,419	218,277

Gender	Alliance	Medicaid FFS	Medicaid MCO
Male	41.9%	50.7%	52.9%
Female	58.1%	49.3%	47.1%



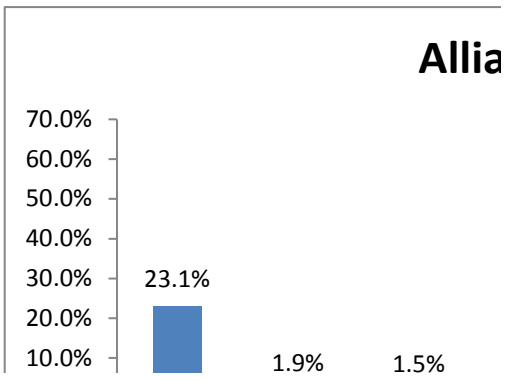
Ward	Alliance	Medicaid FFS	Medicaid MCO
1	6145	5874	21,109
2	1798	12625	17,604
3	474	1449	4,189
4	9095	7361	32,507
5	2207	10174	28,153
6	363	7519	22,866
7	837	11378	42,248
8	379	11258	48,649
Unknown	69	781	952
TOTAL	21,367	68,419	218,277

Ward	Alliance	Medicaid FFS	Medicaid MCO
1	28.8%	8.6%	9.7%
2	8.4%	18.5%	8.1%
3	2.2%	2.1%	1.9%
4	42.6%	10.8%	14.9%
5	10.3%	14.9%	12.9%
6	1.7%	11.0%	10.5%
7	3.9%	16.6%	19.4%
8	1.8%	16.5%	22.3%
Unknown	0.3%	1.1%	0.4%

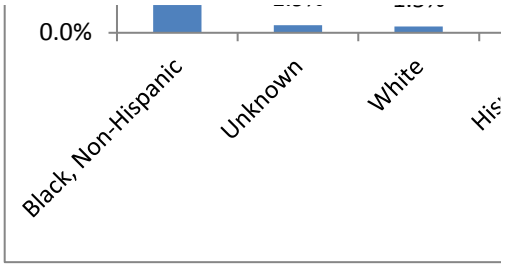


Race/Ethnicity	Alliance	Medicaid FFS	Medicaid MCO
Black, Non-Hispanic	4,940	57,797	163,626
Unknown	401	4,318	24,365
White	331	2,597	2,873
Hispanic	12,441	2,532	20,388
Other	2,737	505	5,180
Asian / Pacific Islander	396	625	1,667
American Indian	121	45	178
TOTAL	21,367	68,419	218,277

Race/Ethnicity	Alliance	Medicaid FFS	Medicaid MCO



Black, Non-Hispanic	23.1%	84.5%	75.0%
Unknown	1.9%	6.3%	11.2%
White	1.5%	3.8%	1.3%
Hispanic	58.2%	3.7%	9.3%
Other	12.8%	0.7%	2.4%
Asian / Pacific Islander	1.9%	0.9%	0.8%
American Indian	0.6%	0.1%	0.1%

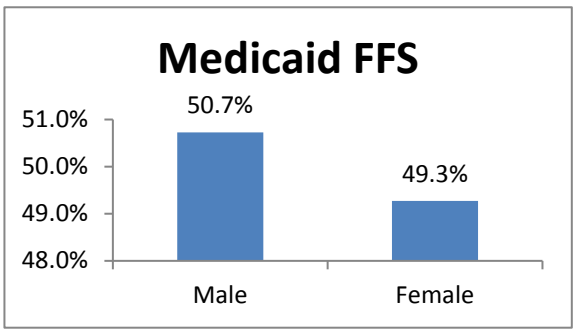


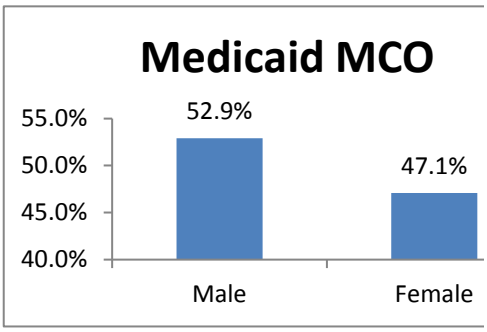
NOTES:

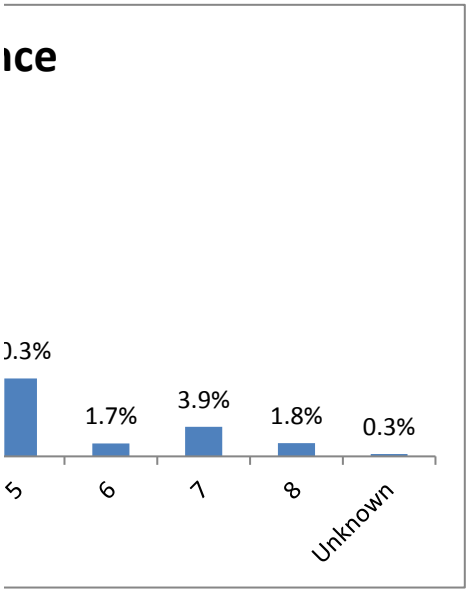
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extracted or

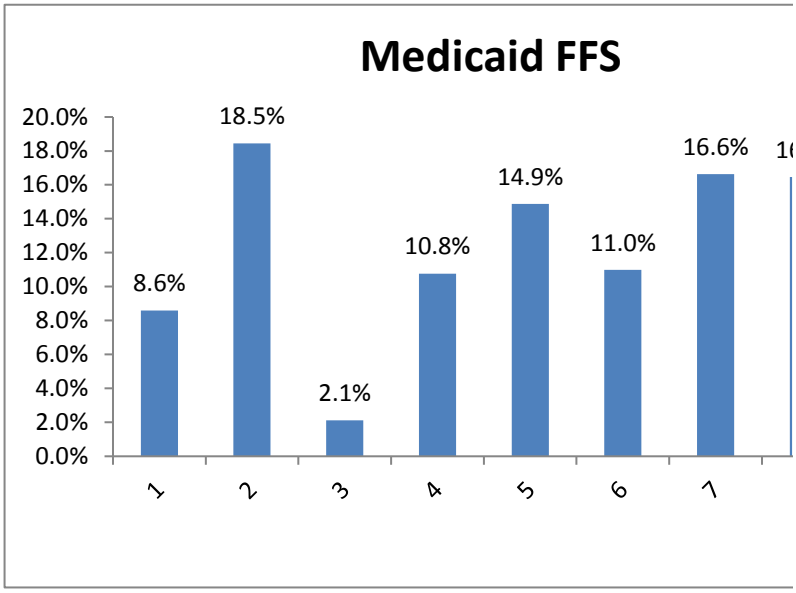
2016.

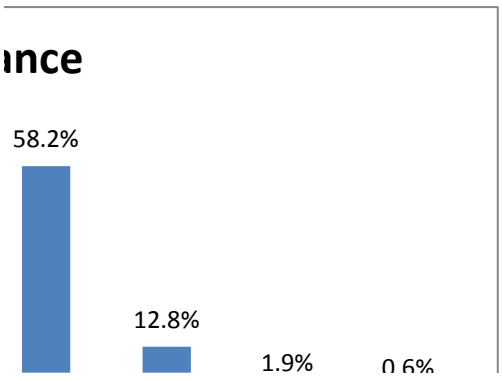
ACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROLLED

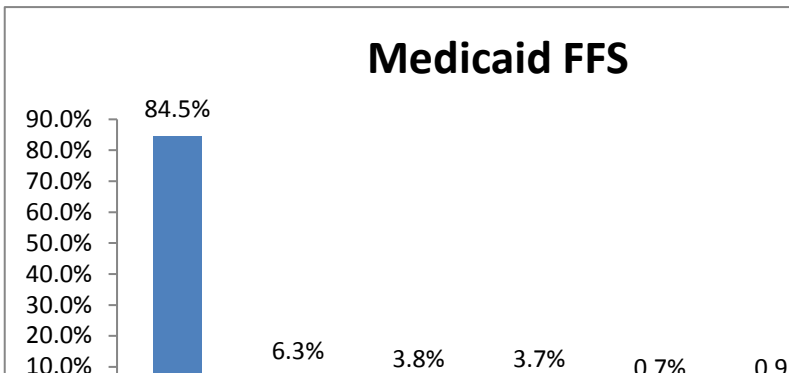


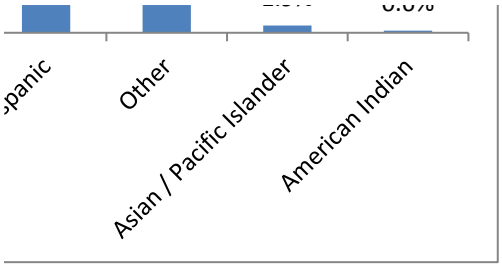


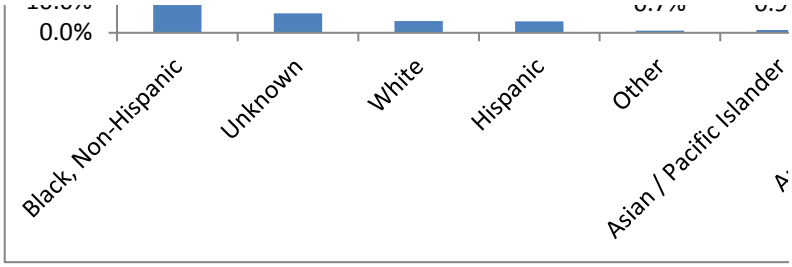






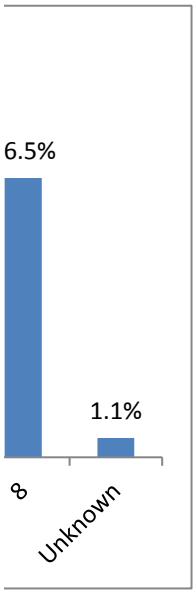


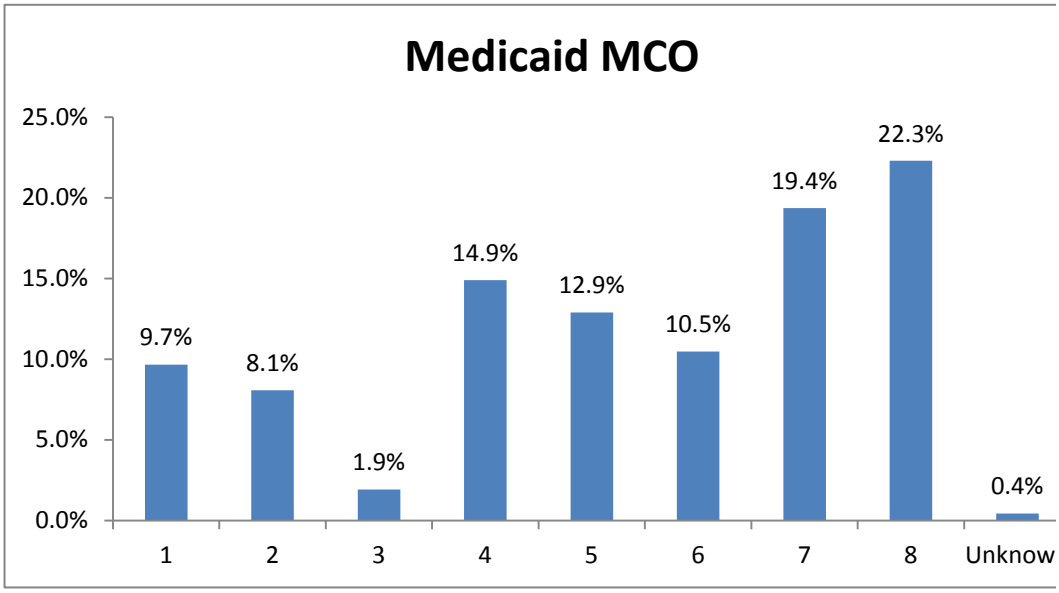


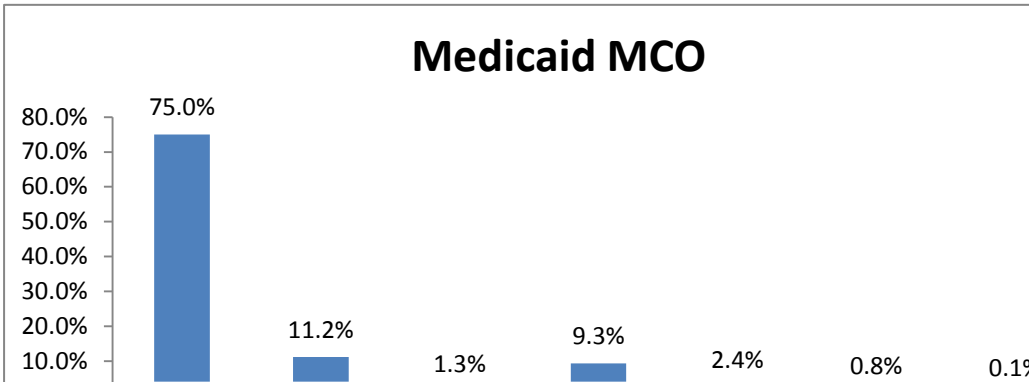


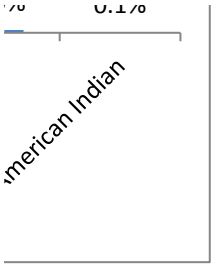
ı February 9, 2017.

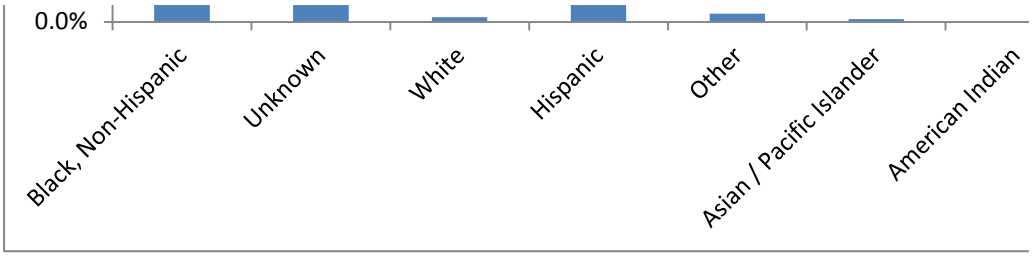
DURING FY16.


6.5%
1.1%
8
Unknown


Medicaid MCO
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
9.7%
8.1%
1.9%
14.9%
12.9%
10.5%
19.4%
22.3%
0.4%
1
2
3
4
5
6
7
8
Unknow


Medicaid MCO
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
75.0%
11.2%
1.3%
9.3%
2.4%
0.8%


0.1%
merican Indian


0.0%
Black, Non-Hispanic
Unknown
White
Hispanic
Other
Asian / Pacific Islander
American Indian

n

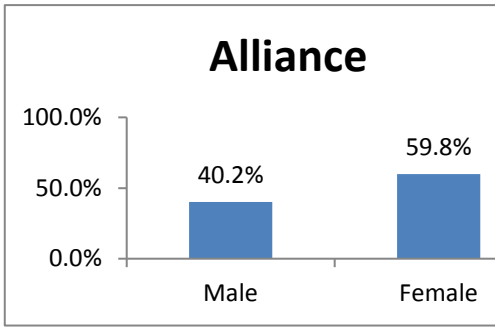
%

This report displays enrollment data for beneficiaries with spans from Oct 1, 2016 through Dec 31, 2

THE TABLES BELOW SHOW DISTRIBUTION BY GENDER, WARD, AND R

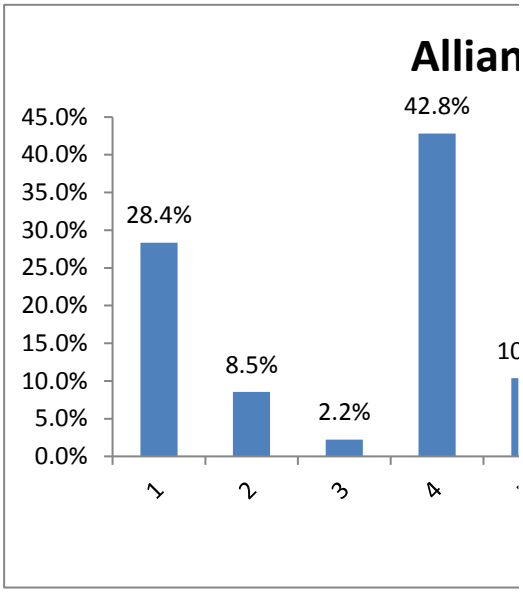
Gender	Alliance	Medicaid FFS	Medicaid MCO
Male	6,792	30,133	91911
Female	10,083	31,847	103433
TOTAL	16,875	61,980	195,344

Gender	Alliance	Medicaid FFS	Medicaid MCO
Male	40.2%	48.6%	47.1%
Female	59.8%	51.4%	52.9%



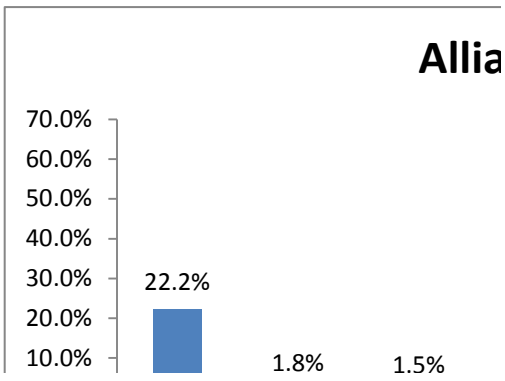
Ward	Alliance	Medicaid FFS	Medicaid MCO
1	4785	5296	18861
2	1441	11023	15298
3	376	1284	3642
4	7225	6599	29020
5	1751	9344	25313
6	273	6864	20243
7	663	10433	38070
8	296	10392	44013
Unknown	65	745	884
TOTAL	16,875	61,980	195,344

Ward	Alliance	Medicaid FFS	Medicaid MCO
1	28.4%	8.5%	9.7%
2	8.5%	17.8%	7.8%
3	2.2%	2.1%	1.9%
4	42.8%	10.6%	14.9%
5	10.4%	15.1%	13.0%
6	1.6%	11.1%	10.4%
7	3.9%	16.8%	19.5%
8	1.8%	16.8%	22.5%
Unknown	0.4%	1.2%	0.5%

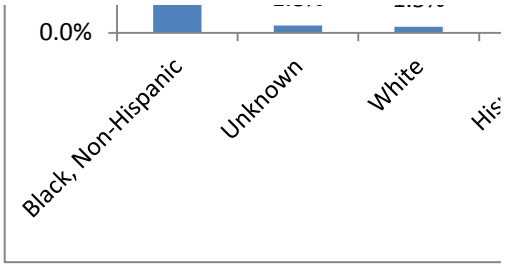


Race/Ethnicity	Alliance	Medicaid FFS	Medicaid MCO
Black, Non-Hispanic	3,747	52,461	146,299
Unknown	302	3,865	22,190
White	256	2,306	2,482
Hispanic	9,942	2,275	18,172
Other	2,227	467	4,618
Asian / Pacific Islander	308	564	1,426
American Indian	93	42	157
TOTAL	16,875	61,980	195,344

Race/Ethnicity	Alliance	Medicaid FFS	Medicaid MCO



Black, Non-Hispanic	22.2%	84.6%	74.9%
Unknown	1.8%	6.2%	11.4%
White	1.5%	3.7%	1.3%
Hispanic	58.9%	3.7%	9.3%
Other	13.2%	0.8%	2.4%
Asian / Pacific Islander	1.8%	0.9%	0.7%
American Indian	0.6%	0.1%	0.1%

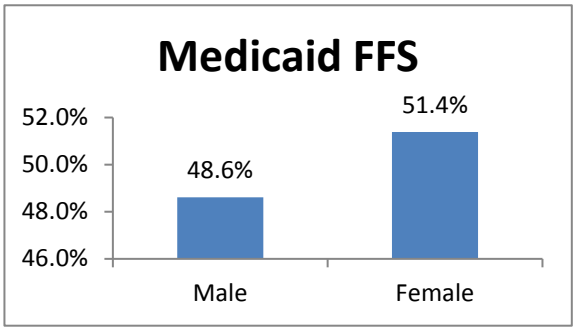


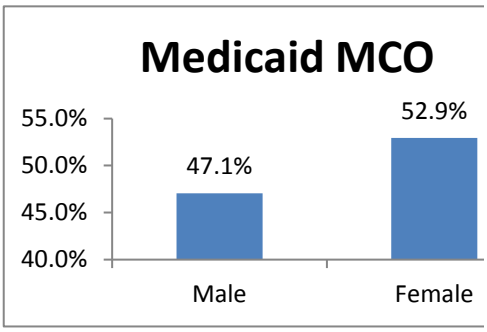
NOTES:

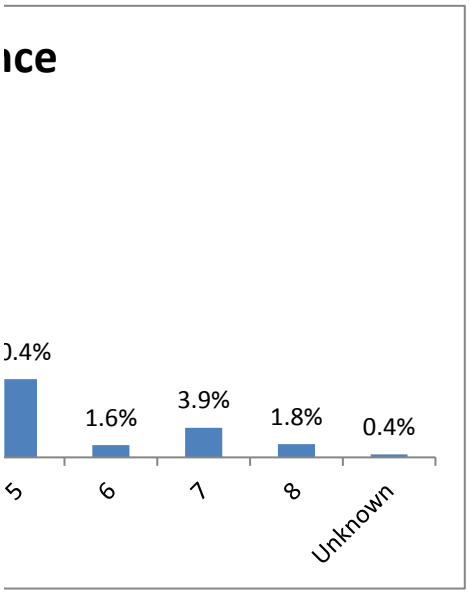
1. Charts are based on DHCF analysis of DC Medicaid Management Information System (MMIS) data extracted or

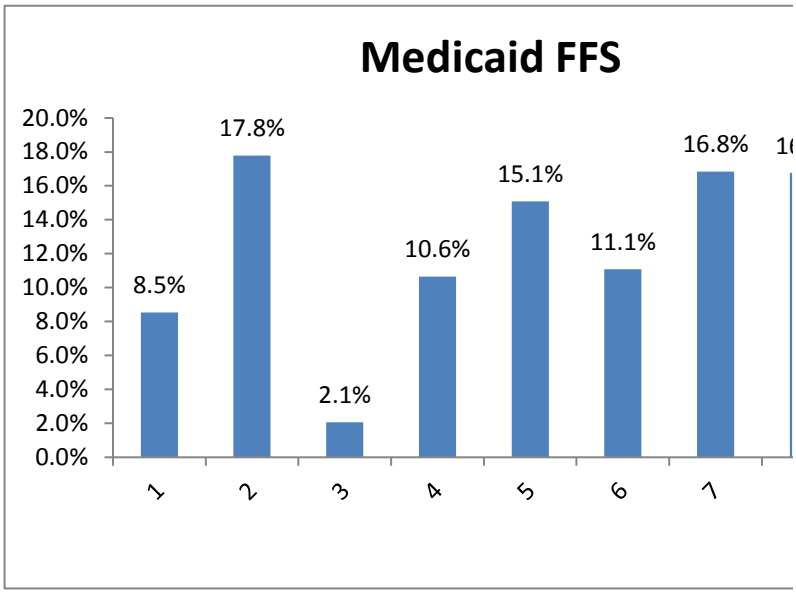
2016.

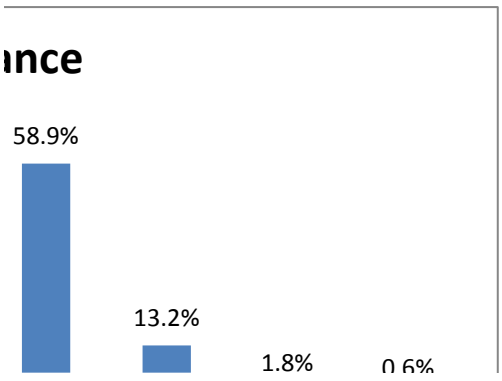
ACE/ETHNICITY FOR UNDUPLICATED INDIVIDUALS EVER-ENROLLED

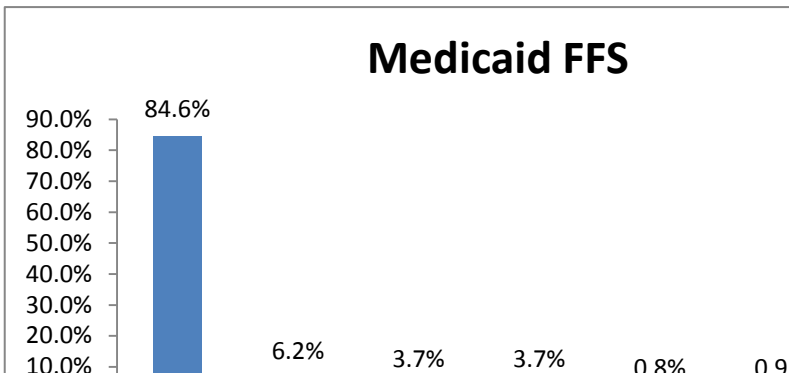


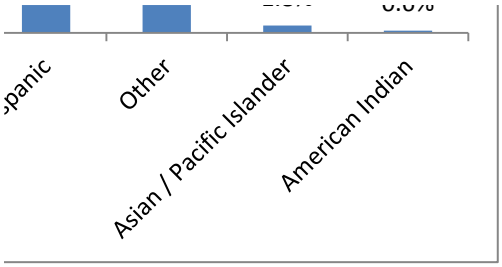


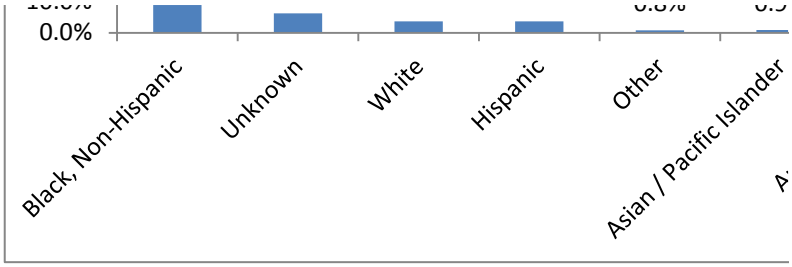






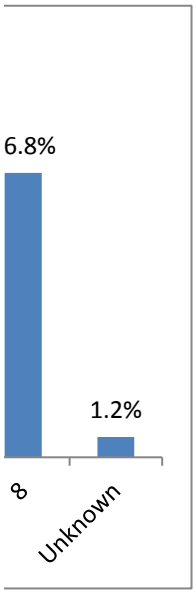


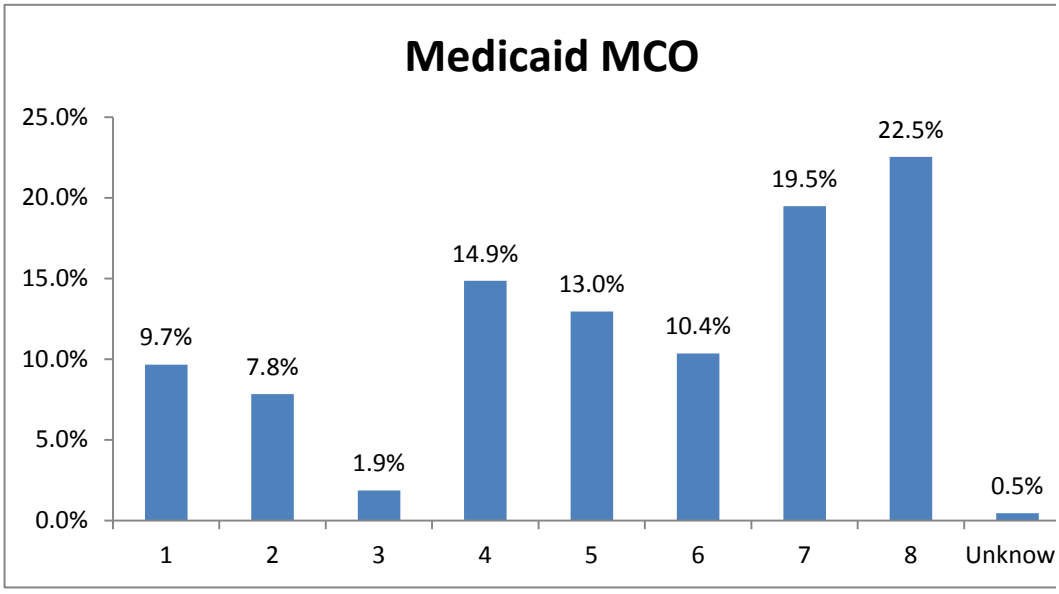


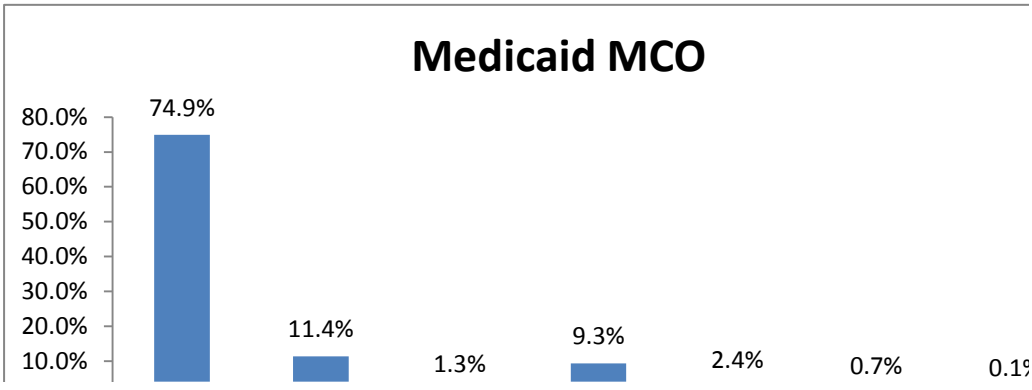


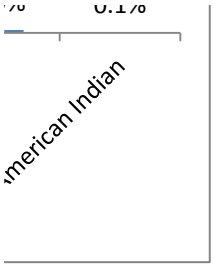
February 9, 2017.

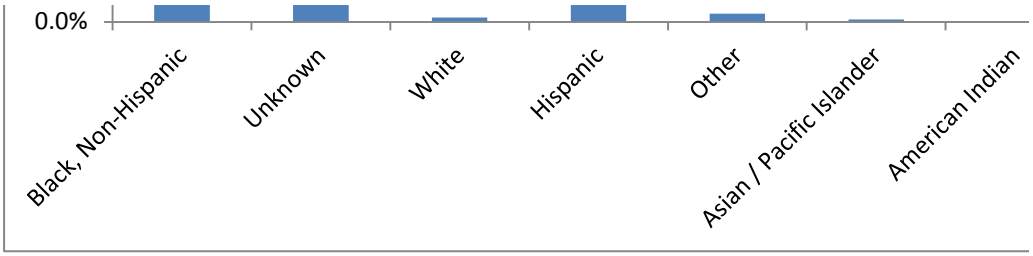
DURING FY17 TO DATE.








0.1%
merican Indian


0.0%
Black, Non-Hispanic
Unknown
White
Hispanic
Other
Asian / Pacific Islander
American Indian

n

%

Age Category	Measures	Quarter 1 CY1	
		AmeriHealth	HSCSN
Sub-Total (Under 3 Years)	# of EPSDT eligibles enrolled in the MCO this quarter	7,158	347
	# of initial, periodic, and interperiodic WCVs	4,609	115
	% of total enrolled EPSDT eligibles who received an EPSDT screen during the Quarter	64.4%	33.1%
	# of individuals receiving Dental services provided by dentist	779	52
	% of EPSDT eligibles enrolled who received a Dental screen during the Quarter	10.9%	15.0%

Age Category	Measures	Quarter 1 CY1	
		AmeriHealth	HSCSN
Sub-Total (3-20 Years)	# of EPSDT eligibles enrolled in the MCO this quarter	42,160	4,087
	# of initial, periodic, and interperiodic WCVs	5,442	725
	% of total enrolled EPSDT eligibles who received an EPSDT screen during the Quarter	12.9%	17.7%
	# of individuals receiving Dental services provided by dentist	11,808	1,176
	% of EPSDT eligibles enrolled who received a Dental screen during the Quarter	28.0%	28.8%

6 (Jan-Mar)		Quarter 2 CY16 (Apr- June)				Quarter 3 CY1	
MedStar	**Trusted**	**AmeriHealth**	**HSCSN**	**MedStar**	**Trusted**	**AmeriHealth**	**HSCSN**
4,165	2,242	7,000	390	4,332	2,270	6,622	356
2,725	1,068	4,350	52	2,780	813	4,385	194
65.4%	47.6%	62.1%	13.3%	64.2%	35.8%	66.2%	54.5%
450	180	885	57	541	934	851	80
10.8%	8.0%	12.6%	14.6%	12.5%	41.1%	12.9%	22.5%

6 (Jan-Mar)		Quarter 2 CY16 (Apr- June)				Quarter 3 CY1	
MedStar	**Trusted**	**AmeriHealth**	**HSCSN**	**MedStar**	**Trusted**	**AmeriHealth**	**HSCSN**
13,159	8,938	41,248	4,177	13,553	9,141	38,459	4,082
1,541	940	6,573	823	2,011	1,195	9,969	1,215
11.7%	10.5%	15.9%	19.7%	14.8%	13.1%	25.9%	29.8%
2,797	1,906	13,169	1,214	3,510	840	13,142	1,290
21.3%	21.3%	31.9%	29.1%	25.9%	9.2%	34.2%	31.6%

6 (July- Sept)	
MedStar	**Trusted**
4,214	2,209
2,847	1,132
67.6%	51.2%
163	0
3.9%	0.0%

6 (July- Sept)	
MedStar	**Trusted**
13,270	8,865
3,198	1,716
24.1%	19.4%
3,637	36
27.4%	0.4%

Table: Total FFS Medicaid Spending By Service Category,

Category of service	Total spending	% of total
Managed Care Payments	$1,025,801,607.07	38%
Inpatient Hospital Services	$278,039,495.96	10%
Nursing Facility Care	$257,771,222.31	10%
DD Waiver Services	$207,144,673.94	8%
Personal Care Services	$180,209,292.24	7%
Mental Health Services	$119,560,534.95	4%
Pharmacy Services	$107,491,513.77	4%
ICF/MR Services	$92,906,448.76	3%
Outpatient Hospital Services	$70,089,406.72	3%
Transportation Services	$51,202,368.77	2%
Federally Qualified Health Center	$46,965,160.13	2%
Physician Services	$46,351,495.58	2%
Hospital DSH Payment	$46,025,669.99	2%
EPD Waiver Services	$40,308,307.62	1%
DCPS	$30,430,626.89	1%
Durable Medical Equipment	$25,911,591.90	1%
Lab and X-Rays Services	$21,055,833.78	1%
Dental Services	$18,572,053.08	1%
Private Clinic Services	$12,018,206.97	0%
All Other	$8,844,895.20	0%
Home Health	$8,661,631.98	0%
Hospice	$5,185,011.54	0%
Residential Treatment Services	$2,661,620.48	0%
Day Treatment	$2,272,857.36	0%
Total	**$2,705,481,526.99**	**100%**

Data Source and Notes: Data extracted from MMIS in November 2016 and reflect final claims, including adjustments, paid during FY16. Categorical assignments based on the service provided code field; some categories have been grouped for simplicity. Pharmacy services have been adjusted to reflect rebates, which are adjudicated outside MMIS. Totals exclude spending for Alliance and Immigrant Children's Program beneficiaries.

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**January-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	59,472
Total Alliance Claims Reviewed in Reporting Period:	5,552
Total Dollars Paid - Medicaid:	$24,375,829.95
Total Dollars Paid - Alliance:	$1,419,829.43

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID
Medicaid	55,162	55,011	**99.73%**	105	**0.19%**	46	**0.08%**
Alliance	5,159	5,158	**99.98%**	1	**0.02%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	4,310	7.25%	1 - HAB - Health - Units Adjust - See Exp Code 2 - XB3 - Members Birthdate Submitted is not valid 3 - X07 - Not a cov bene under members plan 4 - D60 - W-9 requested 5 -123 - Code / Service is non-reimbursable

Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	393	7.08%	1 - AER - Resubmit to DC Medicaid - Emergency Svcs 2 - 123 - Code / Service is non-reimbursable 3 - HAB - Health - Units Adjust - See Exp Code 4 - XB3 - Members Birthdate Submitted is not valid 5 - G00 - PaymentIncluded in OtherBilledService

Claims In Process/Pended

Medicaid	**Total Pended/In Process Claims on Last Day of Review Period**
	11,695

Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	793

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**February-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	69,968
Total Alliance Claims Reviewed in Reporting Period:	6,549
Total Dollars Paid - Medicaid:	$21,371,299.84
Total Dollars Paid - Alliance:	$1,185,461.31

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	65,478	65,430	**99.93%**	46	**0.07%**	1	**0.00%**
Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	5,940	5,940	**100.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	4,490	6.42%	1 - HAB - Health - Units Adjust - See Exp Code 2 - XB3 - Members Birthdate Submitted is not valid 3 - Z89 - Resubmit to EyeQuest 4 - 073 - A1:Deny All Claim Lines 5 -123 - Code / Service is non-reimbursable

Alliance	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
	609	9.30%	1 - G00 - PaymentIncluded in

Claims In Process/Pended

Medicaid	Total Pended/In Process Claims on Last Day of Review Period
	7,191

Alliance	Total Pended/In Process Claims on Last Day of Review Period
	639

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	1	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**March-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	70,201
Total Alliance Claims Reviewed in Reporting Period:	6,511
Total Dollars Paid - Medicaid:	$23,797,602.04
Total Dollars Paid - Alliance:	$1,105,808.78

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	65,734	65,671	**99.90%**	63	**0.10%**	0	**0.00%**
Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	5,961	5,961	**100.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	4,467	6.36%	1 - HAB - Health - Units Adjust - See Exp Code 2 - XB3 - Members Birthdate Submitted is not valid 3 - 123 - Code / Service is non-reimbursable 4 - X07 - Not a cov bene under members plan 5 - 073 - A1:Deny All Claim Lines

Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	550	8.45%	1 - 123 - Code / Service is non-reimbursable 2 - AER - Resubmit to DC Medicaid - Emergency Svcs 3 - G00 - PaymentIncluded in OtherBilledService 4 - HAB - Health - Units Adjust - See Exp Code 5 - Z82 - Resubmit to Avesis

Claims In Process/Pended

Medicaid	**Total Pended/In Process Claims on Last Day of Review Period**
	10,119

Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	1,179

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**April-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	62,127
Total Alliance Claims Reviewed in Reporting Period:	5,516
Total Dollars Paid - Medicaid:	$22,880,850.32
Total Dollars Paid - Alliance:	$899,455.77

Claims Payment

Medicaid	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID
	58,624	58,582	**99.93%**	42	**0.07%**	0	**0.00%**

Alliance	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID
	5,059	5,058	**99.98%**	1	**0.02%**	0	**0.00%**

Claims Denials

Medicaid	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
	3,503	5.64%	1 - HAB - Health - Units Adjust - See Exp Code 2 - X07 - Not a cov bene under members plan 3 - 123 - Code / Service is non-reimbursable 4 - XB3 - Members Birthdate Submitted is not valid 5 - 073 - A1:Deny All Claim Lines

Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	457	8.28%	1 - G00 - PaymentIncluded in OtherBilledService 2 - AER - Resubmit to DC Medicaid - Emergency Svcs 3 - HAB - Health - Units Adjust - See Exp Code 4 - D57 - Submit claim to Lab Corp 5 - X07 - Not a cov bene under members plan

Claims In Process/Pended

Medicaid	**Total Pended/In Process Claims on Last Day of Review Period**
	14,684

Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	1,353

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**May-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	80,472
Total Alliance Claims Reviewed in Reporting Period:	7,050
Total Dollars Paid - Medicaid:	$26,494,673.33
Total Dollars Paid - Alliance:	$1,383,758.77

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID
Medicaid	76,202	76,166	**99.95%**	33	**0.04%**	3	**0.00%**
Alliance	6,574	6,572	**99.97%**	2	**0.03%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	4,270	5.31%	1 - HAB - Health - Units Adjust - See Exp Code 2 - X07 - Not a cov bene under members plan 3 - XB3 - Members Birthdate Submitted is not valid 4 - 123 - Code / Service is non-reimbursable 5 - 073 - A1:Deny All Claim Lines

Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	476	6.75%	1 - HAB - Health - Units Adjust - See Exp Code 2 - G00 - PaymentIncluded in OtherBilledService 3 - 123 - Code / Service is non-reimbursable 4 - D57 - Submit claim to Lab Corp 5 - X07 - Not a cov bene under members plan

Claims In Process/Pended

Medicaid	**Total Pended/In Process Claims on Last Day of Review Period**
	6,730

Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	560

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**June-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	64,661
Total Alliance Claims Reviewed in Reporting Period:	5,260
Total Dollars Paid - Medicaid:	$24,335,957.86
Total Dollars Paid - Alliance:	$1,223,839.88

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	61,093	61,053	**99.93%**	30	**0.05%**	10	**0.02%**

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	4,927	4,926	**99.98%**	1	**0.02%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	3,568	5.52%	1 - HAB - Health - Units Adjust - See Exp Code 2 - XB3 - Members Birthdate Submitted is not valid 3 - X07 - Not a cov bene under members plan 4 - 073 - A1:Deny All Claim Lines 5 - 123 - Code / Service is non-reimbursable

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	**333**	6.33%	1 - 123 - Code / Service is non-reimbursable 2 - HAB - Health - Units Adjust - See Exp Code 3 - X07 - Not a cov bene under members plan 4 -AER - Resubmit to DC Medicaid - Emergency Svcs 5 - XB3 - Members Birthdate Submitted is not valid

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	10,606

	Total Pended/In Process Claims on Last Day of Review Period
Alliance	**1,227**

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**July-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	57,234
Total Alliance Claims Reviewed in Reporting Period:	5,773
Total Dollars Paid - Medicaid:	$22,170,194.09
Total Dollars Paid - Alliance:	$1,080,027.07

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	54,343	54,295	**99.91%**	31	**0.06%**	17	**0.03%**

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	5,370	5,358	**99.78%**	12	**0.22%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	2,891	5.05%	1 - HAB - Health - Units Adjust - See Exp Code 2 - XB3 - Members Birthdate Submitted is not valid 3 - 123 - Code / Service is non-reimbursable 4 - X07 - Not a cov bene under members plan 5 - 073 - A1:Deny All Claim Lines

Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	403	6.98%	1 - X07 - Not a cov bene under members plan 2 - HAB - Health - Units Adjust - See Exp Code 3 - **123 - Code / Service is non-reimbursable** 4 - XB3 - Members Birthdate Submitted is not valid 5 - AER - Resubmit to DC Medicaid - Emergency Svcs

Claims In Process/Pended

Medicaid	**Total Pended/In Process Claims on Last Day of Review Period**
	11,472

Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	1,135

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**August-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	69,601
Total Alliance Claims Reviewed in Reporting Period:	6,961
Total Dollars Paid - Medicaid:	$26,420,413.98
Total Dollars Paid - Alliance:	$1,447,866.32

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	65,765	65,667	**99.85%**	92	**0.14%**	5	**0.01%**
Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	6,549	6,539	**99.85%**	0	**0.00%**	10	**0.15%**

Claims Denials

	Total Denied Claims in Review Period	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
Medicaid	3,836	5.51%	1 - HAB - Health - Units Adjust - See Exp Code 2 - XB3 - Members Birthdate Submitted is not valid 3 - 073 - A1:Deny All Claim Line 4 - X07 - Not a cov bene under members plan 5 - 123 - Code / Service is non-reimbursable

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	**412**	5.92%	1 - 073 - A1:Deny All Claim Line 2 - HAB - Health - Units Adjust - See Exp Code 3 - **123 - Code / Service is non-reimbursable** 4 - AER - Resubmit to DC Medicaid - Emergency Svcs 5 - X07 - Not a cov bene under members plan

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	7,688

	Total Pended/In Process Claims on Last Day of Review Period
Alliance	**636**

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	1	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**September-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	56,935
Total Alliance Claims Reviewed in Reporting Period:	5,455
Total Dollars Paid - Medicaid:	$25,849,852.65
Total Dollars Paid - Alliance:	$1,647,620.63

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	53,962	53,948	**99.97%**	14	**0.03%**	0	**0.00%**

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	5,104	5,104	**100.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	2,973	5.22%	1 - HAB - Health - Units Adjust - See Exp Code 2 - D60 - W-9 requested 3 - X07 - Not a cov bene under members plan 4 - XB3 - Members Birthdate Submitted is not valid 5 - 073 - A1:Deny All Claim Lines

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	**351**	6.43%	1 - HAB - Health - Units Adjust - See Exp Code 2 - 123 - Code / Service is non-reimbursable 3 - X07 - Not a cov bene under members plan 4 - AER - Resubmit to DC Medicaid - Emergency Svcs 5 - 073 - A1:Deny All Claim Lines

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	14,305

	Total Pended/In Process Claims on Last Day of Review Period
Alliance	**1,130**

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**October-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	77,544
Total Alliance Claims Reviewed in Reporting Period:	6727
Total Dollars Paid - Medicaid:	$25,209,274.30
Total Dollars Paid - Alliance:	$1,453,532.66

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	70,355	70,332	**99.97%**	23	**0.03%**	0	**0.00%**

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	6,323	6,323	**100.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	7,189	9.27%	1 - X07 - Not a cov bene under members plan 2 - HAB - Health - Units Adjust - See Exp Code 3 - D60 - W-9 requested 4 - 123 - Code / Service is non-reimbursable 5 - 073 - A1:Deny All Claim Lines

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	**404**	6.01%	1 - HAB - Health - Units Adjust - See Exp Code 2 - 073 - A1:Deny All Claim Lines 3 - X07 - Not a cov bene under members plan 4 - AER - Resubmit to DC Medicaid - Emergency Svcs 5 - 123 - Code / Service is non-reimbursable

Claims In Process/Pended

Medicaid	Total Pended/In Process Claims on Last Day of Review Period
	2,959

Alliance	Total Pended/In Process Claims on Last Day of Review Period
	371

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**AmeriHealth**
Review Period:	**November-16**
MCO Contact Name:	**Keith Fluehr**
MCO Contact Phone Number:	**215-863-5615**
Total Medicaid Claims Reviewed in Reporting Period:	61,302
Total Alliance Claims Reviewed in Reporting Period:	5970
Total Dollars Paid - Medicaid:	$24,004,219.73
Total Dollars Paid - Alliance:	$1,245,928.88

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	56,750	56,740	**99.98%**	10	**0.02%**	0	**0.00%**
Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**
	5,659	5,659	**100.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
Medicaid	**4,552**	7.43%	1 - HAB - Health - Units Adjust - See Exp Code 2 - X07 - Not a cov bene under members plan 3 - 123 - Code / Service is non-reimbursable 4 - D60 - W-9 requested 5 - XB3 - Members Birthdate Submitted is not valid

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	311	5.21%	1 - 123 - Code / Service is non-reimbursable 2 - HAB - Health - Units Adjust - See Exp Code 3 - X07 - Not a cov bene under members plan 4 - AER - Resubmit to DC Medicaid - Emergency Svcs 5 - XB3 - Members Birthdate Submitted is not valid

Claims In Process/Pended

Medicaid	Total Pended/In Process Claims on Last Day of Review Period
	6,903

Alliance	Total Pended/In Process Claims on Last Day of Review Period
	555

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	0.00%	0	0.00%

Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
0	**0.00%**	0	**0.00%**

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**January-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	84,814
Total Alliance Claims Reviewed in Reporting Period:	6,060
Total Dollars Paid - Medicaid:	$ 19,578,753.94
Total Dollars Paid - Alliance:	$ 999,730.78

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	78,817	78,806	**99.99%**	6	**0.01%**	4	**0.01%**	0	**0.02%**	1	**0.00%**

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	4,721	4,720	**99.98%**	0	**0.00%**	0	**0.00%**	1	**0.00%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	5,997	**7.07%**	1- No Associated HCPC or CPT Code with Revenue Code 2- J-code has been billed with the incorrect Revenue Code 3- Carve Out to DHMH 4- Send to Behavioral Health Vendor 5- Observation room billing requires related G or E and M code

Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	1,339	**22.10%**	1- Service Included in Primary Rate 2- Paid at Value of Fee Schedule 3- No Associated HCPC or CPT Code with Revenue Code 4- J-code has been billed with the incorrect Revenue Code

Claims In Process/Pended

Medicaid	**Total Pended/In Process Claims on Last Day of Review Period**
	312

Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	1

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**February-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	83,175
Total Alliance Claims Reviewed in Reporting Period:	8,107
Total Dollars Paid - Medicaid:	$ 15,422,971.66
Total Dollars Paid - Alliance:	$ 1,794,470.04

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	77,349	77,314	**99.95%**	20	**0.03%**	15	**0.02%**	0	**0.00%**	0	

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	7,014	7,013	**99.99%**	1	**0.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	5,826	**7.00%**	1- Paid at Value of Fee Schedule 2- No Associated HCPC or CPT Code with Revenue Code 3- J-code has been billed with the incorrect Revenue Code 4- Send to Behavioral Health Vendor 5- Observation room billing requires related G or E and M code

Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	1,093	**13.48%**	1- Unable to locate Fee Schedule record* 2- Service Included in Primary Rate 3- Paid at Value of Fee Schedule 4- No Associated HCPC or CPT Code with Revenue Code 5- Send to Behavioral Health Vendor

Claims In Process/Pended

Medicaid	**Total Pended/In Process Claims on Last Day of Review Period**
	79

Alliance	**Total Pended/In Process Claims on Last Day of Review Period**

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**March-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	95,789
Total Alliance Claims Reviewed in Reporting Period:	6,849
Total Dollars Paid - Medicaid:	$ 17,390,576.09
Total Dollars Paid - Alliance:	$ 1,256,306.41

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	89,235	88,078	**98.70%**	0	**0.00%**	1	**0.00%**	1	**0.00%**	0	**0.00%**
Alliance	5,644	5,642	**99.96%**	2	**0.03%**	0	**0.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	6,554	**6.84%**	1- Only Physical Therapists can bill for Physical Therapy Services 2- J-code has been billed with the incorrect Revenue Code 3- Carve Out to DHMH 4- Send to Behavioral Health Vendor 5- Observation room billing requires related G or E and M code
Alliance	1,205	**17.59%**	1- Service Included in Primary Rate 2- Paid at Value of Fee Schedule 3- No Associated HCPC or CPT Code with Revenue Code 4- J-code has been billed with the incorrect Revenue Code 5- Send to Behavioral Health Vendor

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	1,620
Alliance	1

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**April-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	89,964
Total Alliance Claims Reviewed in Reporting Period:	5,996
Total Dollars Paid - Medicaid:	$ 13,539,065.36
Total Dollars Paid - Alliance:	$ 1,146,177.88

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	82,899	82,895	**100.00%**	3	**0.01%**	0	**0.00%**	0	**0.00%**	1	**0.00%**

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	4,760	4,760	**100.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

Medicaid	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	7,065	**7.85%**	1- Service not covered per fee schedule 2- Only Physical Therapists can bill for Physical Therapy Services 3- J-code has been billed with the incorrect Revenue Code 4- Send to Behavioral Health Vendor 5- Observation room billing requires related G or E and M code

Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	1,236	**20.61%**	1- Service Included in Primary Rate 2- Paid at Value of Fee Schedule 3- No Associated HCPC or CPT Code with Revenue Code 4- Service not covered per fee schedule 5- Send to Behavioral Health Vendor

Claims In Process/Pended

Medicaid	**Total Pended/In Process Claims on Last Day of Review Period**
	1,025

Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	3

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**May-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	101,391
Total Alliance Claims Reviewed in Reporting Period:	7,820
Total Dollars Paid - Medicaid:	$ 17,482,685.59
Total Dollars Paid - Alliance:	$ 1,709,092.57

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	93,677	93,675	**100.00%**	1	**0.00%**	1	**0.00%**	0	**0.00%**	0	**0.00%**
Alliance	6,113	6,113	**100.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	7,714	7.61%	1- No Associated HCPC or CPT Code with Revenue Code 2- Service not covered per fee schedule 3- J-code has been billed with the incorrect Revenue Code 4- Carve Out to DHMH 5- Send to Behavioral Health Vendor
Alliance	1,707	21.83%	1- Service Included in Primary Rate 2- Paid at Value of Fee Schedule 3- No Associated HCPC or CPT Code with Revenue Code 4- Service not covered per fee schedule

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	1,298
Alliance	0

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**June-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	90,815
Total Alliance Claims Reviewed in Reporting Period:	8,842
Total Dollars Paid - Medicaid:	$ 16,010,984.38
Total Dollars Paid - Alliance:	$ 1,896,957.85

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	83,207	83,206	**100.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**	1	**0.00%**
Alliance	7,383	7,383	**100.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	7,608	8.38%	1- J-code has been billed with the incorrect Revenue Code 2- Carve Out to DHMH 3- Send to Behavioral Health Vendor 4- Observation room billing requires related G or E and M code 5- Associated Vaccine Code must be billed with the administration code

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	1,459	16.50%	1- Paid at Value of Fee Schedule 2- No Associated HCPC or CPT Code with Revenue Code 3- Service not covered per fee schedule 4- J-code has been billed with the incorrect Revenue Code 5- Send to Behavioral Health Vendor

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	17,083
Alliance	2,595

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**July-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	89,041
Total Alliance Claims Reviewed in Reporting Period:	12,114
Total Dollars Paid - Medicaid:	$ 15,957,114.08
Total Dollars Paid - Alliance:	$ 1,941,425.80

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	81,561	81,560	**100.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**	1	**0.00%**
Alliance	10,676	10,676	**100.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	7,480	8.40%	1- J-code has been billed with the incorrect Revenue Code 2- Carve Out to DHMH 3- Send to Behavioral Health Vendor 4- Observation room billing requires related G or E and M code 5- Associated Vaccine Code must be billed with the administration code
Alliance	1,438	11.87%	1- Paid at Value of Fee Schedule 2- No Associated HCPC or CPT Code with Revenue Code 3- Service not covered per fee schedule 4- J-code has been billed with the incorrect Revenue Code 5- Send to Behavioral Health Vendor

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	583
Alliance	348

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**August-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	103,077
Total Alliance Claims Reviewed in Reporting Period:	12,550
Total Dollars Paid - Medicaid:	$ 20,506,351.00
Total Dollars Paid - Alliance:	$ 2,078,885.71

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	93,706	93,702	**100.00%**	3	**0.01%**	1	**0.00%**	0	**0.00%**	0	**0.00%**
Alliance	10,895	10,894	**99.99%**	0	**0.00%**	1	**0.01%**	0	**0.00%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	9,371	9.09%	1- No Associated HCPC or CPT Code with Revenue Code 2- Service not covered per fee schedule 3- J-code has been billed with the incorrect Revenue Code 4- Send to Behavioral Health Vendor: Beacon Health PO Box 383 Latham NY 12110 5- Associated Vaccine Code must be billed with the administration code
Alliance	1,655	13.19%	1- Unable to locate Fee Schedule record* 2- Service Included in Primary Rate 3- Paid at Value of Fee Schedule 4- No Associated HCPC or CPT Code with Revenue Code 5- Service not covered per fee schedule

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	647
Alliance	1

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**September-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	83,835
Total Alliance Claims Reviewed in Reporting Period:	9,576
Total Dollars Paid - Medicaid:	$ 14,037,762.85
Total Dollars Paid - Alliance:	$ 1,466,350.14

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	77,987	77,923	**99.92%**	5	**0.01%**	8	**0.02%**	23	**0.06%**	27	**0.07%**
Alliance	8,796	8,793	**99.97%**	0	**0.00%**	0	**0.01%**	2	**0.04%**	1	**0.02%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	5,848	6.98%	1- Only Physical Therapists can bill for Physical Therapy Services 2- J-code has been billed with the incorrect Revenue Code 3- Carve Out to DHMH: Send to Beacon Health PO Box 1950 Latham NY 12110 4- Send to Behavioral Health Vendor: Beacon Health PO Box 383 Latham NY 12110 5- Associated Vaccine Code must be billed with the administration code
Alliance	780	8.15%	1- Paid at Value of Fee Schedule 2- No Associated HCPC or CPT Code with Revenue Code 3- Service not covered per fee schedule 4- Send to Behavioral Health Vendor: Beacon Health PO Box 383 Latham NY 12110 5- Observation room billing requires related G or E and M code

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	1,255
Alliance	1

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**October-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	95,385
Total Alliance Claims Reviewed in Reporting Period:	11,596
Total Dollars Paid - Medicaid:	$ 16,856,767.40
Total Dollars Paid - Alliance:	$ 1,352,244.43

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	88,223	88,221	**99.98%**	2	**0.01%**	0	**0.02%**	0	**0.06%**	0	**0.07%**
Alliance	10,492	10,491	**99.99%**	1	**0.01%**	0	**0.00%**	0	**0.00%**	0	**0.02%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	7,162	7.51%	1- Only Physical Therapists can bill for Physical Therapy Services 2- J-code has been billed with the incorrect Revenue Code 3- Send to Behavioral Health Vendor: Beacon Health PO Box 383 Latham NY 12110 4- Observation room billing requires related G or E and M code 5- Associated Vaccine Code must be billed with the administration code

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	1,104	9.52%	1- Paid at Value of Fee Schedule 2- No Associated HCPC or CPT Code with Revenue Code 3- Service not covered per fee schedule 4- J-code has been billed with the incorrect Revenue Code 5- Send to Behavioral Health Vendor: Beacon Health PO Box 383 Latham NY 12110

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	9,331
Alliance	1,340

CLAIMS MONTHLY REPORT

MCO Name:	**MedStar**
Review Period:	**November-16**
MCO Contact Name:	**Tim Sullivan**
MCO Contact Phone Number:	**202-243-2523**
Total Medicaid Claims Reviewed in Reporting Period:	92,923
Total Alliance Claims Reviewed in Reporting Period:	11,738
Total Dollars Paid - Medicaid:	$ 16,282,596.31
Total Dollars Paid - Alliance:	$ 1,453,744.03

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	85,324	85,321	**100.00%**	2	**0.00%**	1	**0.00%**	0	**0.00%**	0	**0.00%**
Alliance	10,635	10,634	**99.99%**	1	**0.00%**	0	**0.00%**	0	**0.00%**	0	**0.00%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	7,599	8.18%	1- Only Physical Therapists can bill for Physical Therapy Services 2- J-code has been billed with the incorrect Revenue Code 3- Send to Behavioral Health Vendor: Beacon Health PO Box 383 Latham NY 12110 4- Observation room billing requires related G or E and M code 5- Associated Vaccine Code must be billed with the administration code

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	1,103	9.40%	1- Paid at Value of Fee Schedule 2- No Associated HCPC or CPT Code with Revenue Code 3- Service not covered per fee schedule 4- J-code has been billed with the incorrect Revenue Code 5- Send to Behavioral Health Vendor: Beacon Health PO Box 383 Latham NY 12110

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	9,057
Alliance	1,340

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**January-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	20,632
Total Alliance Claims Reviewed in Reporting Period:	5,127
Total Dollars Paid - Medicaid:	**$7,409,475.71**
Total Dollars Paid - Alliance:	**$1,288,563.62**

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	15,901	14,138	**88.91%**	1,537	**9.67%**	81	**0.51%**	81	**0.51%**	64	**0.40%**

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	3,631	3,123	**86.01%**	422	**11.62%**	31	**0.85%**	29	**0.80%**	26	**0.72%**
Summary	**19,532**	17,261	**88.37%**	1,959	**10.03%**	112	**0.57%**	110	**0.56%**	90	**0.46%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	4,731	22.93%	D22 REJECTED - NO VALID AUTH ON FILE (3112) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (1226) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (1205) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (929) D25 DENIED- DUPLICATE CLAIM PAID/DENIED PREV (793)
Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	1,496	29.18%	D22 REJECTED - NO VALID AUTH ON FILE (802) D75 SVCS NOT COVD¿REFER TO DISTRICT FOR PROC(446) D77 SERVICES NOT COVERED BY THIS PLAN (425) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (384) D25 DENIED- DUPLICATE CLAIM PAID/DENIED PREV (314)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	**6,300**
Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	1,625

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**February-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	17,159
Total Alliance Claims Reviewed in Reporting Period:	3,393
Total Dollars Paid - Medicaid:	**$4,945,550.20**
Total Dollars Paid - Alliance:	**$712,741.64**

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	**13,587**	12,925	**95.13%**	465	**3.42%**	132	**0.97%**	51	**0.38%**	14	**0.10%**
Alliance	**2,313**	2,184	**94.42%**	97	**4.19%**	18	**0.78%**	13	**0.56%**	1	**0.04%**
Summary	**15,900**	15,109	**95.03%**	562	**3.53%**	150	**0.94%**	64	**0.40%**	15	**0.09%**

Based on the MCO's/CASSIP's best knowledge and information, the MCO/CASSIP in submitting this data to the DHCF attests to the accuracy, completeness and truthfulness of the data, in accordance with 42 CFR 438.604 and 438.606.

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	3,572	20.82%	D22 REJECTED - NO VALID AUTH ON FILE(2444) D8 REJECTED;EXPENSES INCURRED AFTER COVERAG (691) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (674) D222 LAB SERV NOT PAYABLE-SHOULD BE RENDERED (671) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (543)
Alliance	1,080	31.83%	D22 REJECTED - NO VALID AUTH ON FILE(601) D77 SERVICES NOT COVERED BY THIS PLAN (402) D8 REJECTED;EXPENSES INCURRED AFTER COVERAG (349) 295 SERVICES INCLUDED IN THE DIALYSIS TREATM (281) D75 SVCS NOT COVD;REFER TO DISTRICT FOR PROC (209)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	**7,733**
Alliance	**1,958**

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**March-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	27,030
Total Alliance Claims Reviewed in Reporting Period:	6,576
Total Dollars Paid - Medicaid:	**$8,714,115.16**
Total Dollars Paid - Alliance:	**$1,201,682.75**

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	**21,765**	19,862	**91.26%**	1,819	**8.36%**	60	**0.28%**	16	**0.07%**	8	**0.04%**
Alliance	**4,891**	4,415	**90.27%**	444	**9.08%**	16	**0.33%**	9	**0.18%**	7	**0.14%**
Summary	**26,656**	24,277	**91.08%**	2,263	**8.49%**	76	**0.29%**	25	**0.09%**	15	**0.06%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	5,265	19.48%	D22 REJECTED - NO VALID AUTH ON FILE (2693) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (1352) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (1177) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (1078) D222 LAB SERV NOT PAYABLE-SHOULD BE RENDERED (760)
Alliance	1,685	25.62%	D77 SERVICES NOT COVERED BY THIS PLAN (710) D22 REJECTED - NO VALID AUTH ON FILE (749) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (537) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (207) D75 SVCS NOT COVD¿REFER TO DISTRICT FOR PROC (205)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	7,632
Alliance	2,264

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**April-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	21,380
Total Alliance Claims Reviewed in Reporting Period:	4,625
Total Dollars Paid - Medicaid:	**$5,636,480.35**
Total Dollars Paid - Alliance:	**$702,903.88**

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	**16,787**	15,687	**93.45%**	982	**5.85%**	57	**0.34%**	56	**0.33%**	5	**0.03%**
Alliance	**3,309**	3,000	**90.66%**	273	**8.25%**	23	**0.70%**	12	**0.36%**	1	**0.03%**
Summary	**20,096**	18,687	**92.99%**	1,255	**6.25%**	80	**0.40%**	68	**0.34%**	6	**0.03%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	4,593	21.48%	D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (2584) D22 REJECTED - NO VALID AUTH ON FILE (2053) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (1085) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (843) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (714)
	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	1,316	28.45%	D77 SERVICES NOT COVERED BY THIS PLAN (659) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (330) D22 REJECTED - NO VALID AUTH ON FILE (326) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (264) 295 SERVICES INCLUDED IN THE DIALYSIS TREATM (211)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	7,736
	Total Pended/In Process Claims on Last Day of Review Period
Alliance	1,968

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**May-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	26,733
Total Alliance Claims Reviewed in Reporting Period:	5,460
Total Dollars Paid - Medicaid:	**$6,989,602.99**
Total Dollars Paid - Alliance:	**$1,184,247.55**

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	**21,342**	19,476	**91.26%**	1,741	**8.16%**	76	**0.36%**	42	**0.20%**	7	**0.03%**
Alliance	**3,781**	3,340	**88.34%**	425	**11.24%**	12	**0.32%**	0		4	**0.11%**
Summary	**25,123**	22,816	**90.82%**	2,166	**8.62%**	88	**0.35%**	42	**0.17%**	11	**0.04%**

Based on the MCO's/CASSIP's best knowledge and information, the MCO/CASSIP in submitting this data to the DHCF attests to the accuracy, completeness and truthfulness of the data, in accordance with 42 CFR 438.604 and 438.606.

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	5,391	20.17%	D22 REJECTED - NO VALID AUTH ON FILE (2823) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (2228) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (1554) D41 DENIED-OBSERVATION HRS EXCEEDED-RESUBMIT (1215) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (1157)
	Total Denied Claims in Review Period	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
Alliance	1,679	30.75%	D77 SERVICES NOT COVERED BY THIS PLAN (871) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (632) D22 REJECTED - NO VALID AUTH ON FILE (491) D75 SVCS NOT COVD¿REFER TO DISTRICT FOR PROC (438) 295 SERVICES INCLUDED IN THE DIALYSIS TREATM (394)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	**8,806**
	Total Pended/In Process Claims on Last Day of Review Period
Alliance	**2,809**

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**June-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	27,693
Total Alliance Claims Reviewed in Reporting Period:	6,505
Total Dollars Paid - Medicaid:	**$9,854,203.66**
Total Dollars Paid - Alliance:	**$1,156,180.51**

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	22,592	22,040	**97.56%**	440	**1.95%**	94	**0.42%**	10	**0.04%**	8	**0.04%**
Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	4,194	4,102	**97.81%**	80	**1.91%**	8	**0.19%**	4	**0.10%**	0	
Summary	**26,786**	26,142	**97.60%**	520	**1.94%**	102	**0.38%**	14	**0.05%**	8	**0.03%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	5,101	18.42%	D22 REJECTED - NO VALID AUTH ON FILE (2379) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (2307) D8 REJECTED;EXPENSES INCURRED AFTER COVERAG (1403) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (1033) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (848)
Alliance	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
	2,311	35.53%	D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (3123) D77 SERVICES NOT COVERED BY THIS PLAN (948) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (694) D75 SVCS NOT COVD;REFER TO DISTRICT FOR PROC (547) D22 REJECTED - NO VALID AUTH ON FILE (537)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	5,104
Alliance	Total Pended/In Process Claims on Last Day of Review Period
	1,196

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**July-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	20,035
Total Alliance Claims Reviewed in Reporting Period:	3,758
Total Dollars Paid - Medicaid:	**$5,775,290.56**
Total Dollars Paid - Alliance:	**$778,039.60**

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	**16,427**	16,156	**98.35%**	160	**0.97%**	88	**0.54%**	14	**0.09%**	9	**0.05%**
Alliance	**2,863**	2,828	**98.78%**	23	**0.80%**	11	**0.38%**	0		1	**0.03%**
Summary	**19,290**	18,984	**98.41%**	183	**0.95%**	99	**0.51%**	14	**0.07%**	10	**0.05%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	3,608	18.01%	D22 REJECTED - NO VALID AUTH ON FILE (1415) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (1036) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (1033) D41 DENIED-OBSERVATION HRS EXCEEDED-RESUBMIT (952) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (921)
Alliance	**Total Denied Claims in Review Period**	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
	895	23.82%	D77 SERVICES NOT COVERED BY THIS PLAN (605) D8 REJECTED¿EXPENSES INCURRED AFTER COVERAG (220) 295 SERVICES INCLUDED IN THE DIALYSIS TREATM (194) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (178) D22 REJECTED - NO VALID AUTH ON FILE (172)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	**4,194**
Alliance	**Total Pended/In Process Claims on Last Day of Review Period**
	1,008

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**August-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	22,152
Total Alliance Claims Reviewed in Reporting Period:	4,613
Total Dollars Paid - Medicaid:	**$7,559,044.29**
Total Dollars Paid - Alliance:	**$1,421,502.97**

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	**17,849**	17,279	**96.81%**	516	**2.89%**	46	**0.26%**	2	**0.01%**	6	**0.03%**
Alliance	**3,285**	3,157	**96.10%**	111	**3.38%**	2	**0.06%**	15	**0.46%**	0	
Summary	**21,134**	20,436	**96.70%**	627	**2.97%**	48	**0.23%**	17	**0.08%**	6	**0.03%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	4,303	19.42%	D22 REJECTED - NO VALID AUTH ON FILE (2086) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (1429) D8 REJECTED;EXPENSES INCURRED AFTER COVERAG (1408) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (952) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (776)

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	1,328	28.79%	D77 SERVICES NOT COVERED BY THIS PLAN (670) D22 REJECTED - NO VALID AUTH ON FILE (479) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (309) D8 REJECTED;EXPENSES INCURRED AFTER COVERAG (302) DCT (219)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	**6,145**

	Total Pended/In Process Claims on Last Day of Review Period
Alliance	**1,584**

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**September-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	21,948
Total Alliance Claims Reviewed in Reporting Period:	5,569
Total Dollars Paid - Medicaid:	**$6,849,058.17**
Total Dollars Paid - Alliance:	**$1,436,951.88**

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	**17,904**	16,615	**92.80%**	1,191	**6.65%**	69	**0.39%**	13	**0.07%**	16	**0.09%**
Alliance	**3,549**	3,139	**88.45%**	328	**9.24%**	39	**1.10%**	18	**0.51%**	25	**0.70%**
Summary	**21,453**	19,754	**92.08%**	1,519	**7.08%**	108	**0.50%**	31	**0.14%**	41	**0.19%**

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	4,044	18.43%	D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (1841) D8 REJECTED;EXPENSES INCURRED AFTER COVERAG (1606) D22 REJECTED - NO VALID AUTH ON FILE (1473) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (856) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (736)
	Total Denied Claims in Review Period	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
Alliance	2,020	36.27%	D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (1722) D77 SERVICES NOT COVERED BY THIS PLAN (777) 295 SERVICES INCLUDED IN THE DIALYSIS TREATM (612) D22 REJECTED - NO VALID AUTH ON FILE (320) D8 REJECTED;EXPENSES INCURRED AFTER COVERAG (307)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	**4,818**
	Total Pended/In Process Claims on Last Day of Review Period
Alliance	**1,285**

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**October-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	20,600
Total Alliance Claims Reviewed in Reporting Period:	4,240
Total Dollars Paid - Medicaid:	**$8,130,415.79**
Total Dollars Paid - Alliance:	**$854,465.81**

Claims Payment

	Total PAID Claims Reviewed for Period	Total Claims Paid < 31 days from Submission	Percentage % of Total PAID	Total Claims Paid 31-60 days from Submission	Percentage % of Total PAID	Total Claims Paid 61-90 days from Submission	Percentage % of Total PAID	Total Claims Paid 90-120 days from Submission	Percentage % of Total PAID	Total Claims Paid >120 days from Submission	Percentage % of Total PAID
Medicaid	**16,662**	15,338	**92.05%**	1,240	**7.44%**	54	**0.32%**	15	**0.09%**	15	**0.09%**
Alliance	**2,949**	2,586	**87.69%**	346	**11.73%**	7	**0.24%**	6	**0.20%**	4	**0.14%**
Summary	**19,611**	17,924	**91.40%**	1,586	**8.09%**	61	**0.31%**	21	**0.11%**	19	**0.10%**

Based on the MCO's/CASSIP's best knowledge and information, the MCO/CASSIP in submitting this data to the DHCF attests to the accuracy, completeness and truthfulness of the data, in accordance with 42 CFR 438.604 and 438.606.

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	3,938	19.12%	D22 REJECTED - NO VALID AUTH ON FILE (2381) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (1425) D8 REJECTED,EXPENSES INCURRED AFTER COVERAG (1346) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (882) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (652)
	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Alliance	1,291	30.45%	D77 SERVICES NOT COVERED BY THIS PLAN (971) D22 REJECTED - NO VALID AUTH ON FILE (666) D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (517) D75 SVCS NOT COVD,REFER TO DISTRICT FOR PROC (374) D8 REJECTED,EXPENSES INCURRED AFTER COVERAG (245)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	6,691
	Total Pended/In Process Claims on Last Day of Review Period
Alliance	1,487

CLAIMS MONTHLY REPORT

MCO Name:	**Trusted**
Review Period:	**November-16**
MCO Contact Name:	**Doug Redd**
MCO Contact Phone Number:	**(202) 821-1091**
Total Medicaid Claims Reviewed in Reporting Period:	26,411
Total Alliance Claims Reviewed in Reporting Period:	6,192
Total Dollars Paid - Medicaid:	**$8,012,406.50**
Total Dollars Paid - Alliance:	**$1,059,687.93**

Claims Payment

Medicaid	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	21,106	20,022	**94.86%**	1,009	**4.78%**	38	**0.18%**	12	**0.06%**	25	**0.12%**

Alliance	**Total PAID Claims Reviewed for Period**	**Total Claims Paid < 31 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 31-60 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 61-90 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid 90-120 days from Submission**	**Percentage % of Total PAID**	**Total Claims Paid >120 days from Submission**	**Percentage % of Total PAID**
	4,085	3,754	**91.90%**	325	**7.96%**	3	**0.07%**	1	**0.02%**	2	**0.05%**
Summary	**25,191**	23,776	**94.38%**	1,334	**5.30%**	41	**0.16%**	13	**0.05%**	27	**0.11%**

Based on the MCO's/CASSIP's best knowledge and information, the MCO/CASSIP in submitting this data to the DHCF attests to the accuracy, completeness and truthfulness of the data, in accordance with 42 CFR 438.604 and 438.606.

Claims Denials

	Total Denied Claims in Review Period	Percentage % of Total Reviewed	Top 5 Pend/Denial Reasons
Medicaid	5,305	20.09%	D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (2022) D22 REJECTED - NO VALID AUTH ON FILE (1705) D8 REJECTED,EXPENSES INCURRED AFTER COVERAG (1439) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (1380) DAC DUPLICATE OF CLAIM CURRENTLY PROCESSING (1041)
	Total Denied Claims in Review Period	**Percentage % of Total Reviewed**	**Top 5 Pend/Denial Reasons**
Alliance	2,107	34.03%	D10 REJECTED - EXCEEDS MAXIMUM FILING TIME L (1737) D77 SERVICES NOT COVERED BY THIS PLAN (588) D22 REJECTED - NO VALID AUTH ON FILE (492) 295 SERVICES INCLUDED IN THE DIALYSIS TREATM (484) D21 REJECTED- NO REFERRAL/EXPIRED/INVALID RE (356)

Claims In Process/Pended

	Total Pended/In Process Claims on Last Day of Review Period
Medicaid	**7,803**
	Total Pended/In Process Claims on Last Day of Review Period
Alliance	**1,899**

Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **Psychiatric Residential Treatment Facility (PRTF) Medical Necessity Determination Process**		
POLICY NUMBER **DMH Policy 200.7**	DATE JAN 13 2012	TL# 158

Purpose. One of the Department of Mental Health's (DMH's) primary goals is to treat and therefore maintain children/youth within their own communities in the least restrictive and supportive environments. Placing a child or youth in a Psychiatric Residential Treatment Facility (PRTF) is a serious decision and all efforts should be made to address the treatment needs of the child/youth through community based services prior to any PRTF placement.

This policy establishes the procedures for the DMH medical necessity determination process for admission to and continued stays of children and youth in a PRTF whose needs cannot be met in the community.

Applicability. This policy governs (1) DMH medical necessity determinations prior to admitting any Medicaid eligible child or youth in a PRTF, except for those children currently enrolled with a Medicaid Managed Care Organization (MCO); (2) medical necessity determinations for all Medicaid eligible children currently in a PRTF; and (3) medical necessity determinations for all other referrals of children for placement in a PRTF by a District agency.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *This policy is effective immediately.*

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must promptly file this policy with their **DMH** Policy and Procedures, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY
None

INSERT
DMH Policy 200.7

Stephen T. Baron
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 200.7	Date JAN 13 2017	Page 1
	Supersedes None		

Subject: Psychiatric Residential Treatment Facility (PRTF) Medical Necessity Determination Process

1. **Purpose**. One of the Department of Mental Health's (DMH's) primary goals is to treat and therefore maintain children/youth within their own communities in the least restrictive and supportive environments. Placing a child or youth in a Psychiatric Residential Treatment Facility (PRTF) is a serious decision and all efforts should be made to address the treatment needs of the child/youth through community based services prior to any PRTF placement.

This policy establishes the procedures for the DMH medical necessity determination process for admission to and continued stays of children and youth in a PRTF whose needs cannot be met in the community.

2. **Applicability**. This policy governs (1) DMH medical necessity determinations prior to admitting any Medicaid eligible child or youth to a PRTF, except for those children currently enrolled with a Medicaid Managed Care Organization (MCO); (2) medical necessity determinations for all Medicaid eligible children currently in a PRTF; and (3) medical necessity determinations for all other referrals of children for placement in a PRTF by a District agency.

3. **Authority**. 42 CFR § 441.152, Certification of Need for Services; Department of Mental Health Establishment Amendment Act of 2001; Title 22-A, DCMR, Chapter 34, Mental Health Rehabilitation Services (MHRS) Provider Certification Standards; and Title 29 DCMR § 948, Standards for Participation of Residential Treatment Centers for Children and Youth.

4. **Definitions**. For purposes of this policy, the following definition applies:

Psychiatric Residential Treatment Facility (PRTF). A psychiatric facility that (1) is not a hospital; and (2) is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state in which it is located; and (3) provides inpatient psychiatric services for individuals under the age of twenty-two (22) and meets the requirements set forth in §§ 441.151 through 441.182 of Title 42 of the Code of Federal Regulations, and is enrolled by the District of Columbia Department of Health Care Finance (DHCF) to participate in the Medicaid program.

5. **Background**. Pursuant to D.C. Municipal Regulation 29 DCMR § 948, DMH has the authority and responsibility to determine medical necessity for all PRTF placements for Medicaid eligible children and youth. PRTFs are intended for children and youth who are often involved with multiple agencies, who have had difficulty maintaining linkages to community mental health services and other important supports (such as schools, family, peers, and vocational programs) and who are unable to reside safely in the community in a less restrictive setting.

This policy sets forth the requirements and procedures that DMH will follow when conducting medical necessity determinations for all PRTF placements. To ensure an efficient and transparent process, DMH has developed a uniform referral process for admission to PRTFs that requires: (a) participation by an inter-agency PRTF Review Committee; (b) exploration of all community-based alternatives to residential placement before a PRTF placement recommendation is made; and (c) documentation of teaming efforts to stabilize the child/youth, which include an explanation of why lower levels of community services have not been successful, and compelling reasons why placement in a PRTF is necessary. DMH has also developed a uniform referral process for continued stay in a PRTF and criteria that must be met in order for the child/youth to remain in a PRTF beyond the original medical necessity certification.

6. **Policy**.

6a. Community-based alternatives to residential placement must be explored through a teaming process prior to referring a child or youth for psychiatric residential placement, absent exceptional circumstances.

6b. After all efforts have been made to address the treatment needs of the child and youth in the least restrictive, clinically appropriate, community-based setting, a referral for review of medical necessity for placement in a PRTF may be submitted to the PRTF Review Committee for a medical necessity determination.

6c. The PRTF Review Committee shall serve as the single point of access and accountability for medical necessary determinations for PRTF placements and continued stays.

6d. If a child/youth has been ordered to be placed in a PRTF by a court or by a hearing officer determination, the placing agency shall refer the child/youth to the PRTF Review Committee in accordance with Section 8a below.

7. **PRTF Review Committee.**

7a. Role. The PRTF Review Committee is an independent inter-agency team that ensures that referrals for admission to a PRTF and continued stays meet federal guidelines in accordance with 42 CFR § 441.152 in order to issue a medical necessity determination for PRTF placement, D.C. Municipal Regulation 29 DCMR § 948, and the requirements of this policy.

The PRTF Committee will review:

- Referrals of children for placement in a PRTF by a District agency including, but not limited to, DMH, Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), Office of the State Superintendent of Education (OSSE), and DC Public Schools (DCPS);
- Referrals from any other entity seeking PRTF admission for a Medicaid eligible child or youth (e.g., Court Social Services [CSS], or parent or legal guardian);
- Referrals for children who have just been approved for placement in a PRTF by an MCO and the child's insurance will convert to Fee-for-Service Medicaid as a result of the placement in the PRTF; and
- Referrals for children currently in a PRTF for whom continued stay is recommended.

7b. Membership. The following District agencies will appoint in writing one (1) primary and alternate mental health professional to serve on the committee. The committee chairman and non-government members will be appointed by the DMH Director. The PRTF Review Committee shall consist of the following:

- DMH board certified child and adolescent psychiatrist,
- DYRS representative,
- CFSA representative,
- DCPS representative,
- OSSE representative,
- CSS representative,
- Representative from agency designated as the family advocacy group for families with children receiving care from DMH, and
- DMH PRTF Review Coordinator (non-voting member).

7c. PRTF Medical Necessity Determination.

(1) In order to issue a medical necessity determination for placement of a child or youth in a PRTF, the PRTF Review Committee must make the following findings:

(a) Community-based services available in the District do not meet the treatment needs of the child or youth;

(b) Proper treatment of the child or youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(c) Services in a PRTF can reasonably be expected to improve the child or youth's condition or prevent further regression so that PRTF services will no longer be needed.

(2) If the Committee determines that the child or youth does not meet medical necessity for placement in a PRTF and can be served best in the community, the Committee will deny the referral and provide a list of recommended services and actions necessary to properly serve the child or youth's needs in the community.

(3) There must be at least five (5) voting members present in order for the Committee to make a medical necessity determination. A majority vote by committee members participating in the review is required to certify PRTF placement. Only Committee members may be present while the Committee votes.

7d. Meeting Schedule/Minutes.

(1) The PRTF Review Committee will determine its regular meeting schedule. Meetings will be scheduled on a timely basis in order to ensure the timely review of requests for PRTF placements.

(2) The PRTF Coordinator shall record minutes from each PRTF Review Committee meeting and maintain a record of all actions taken on each referral. Records will be maintained in accordance with DMH privacy policies regarding confidentiality of mental health information. Also see Section 10 below.

7e. Annual Report. The PRTF Review Committee will produce an annual report to include:

- summary of all referrals by referral source, date of referral, type, date of committee review, and final decision of the Committee;
- list of PRTFs used and the addresses; and
- trends and recommendations.

8. **Responsibilities**.

8a. **Referring Entities** (as described in Section 7a above) shall:

(1) **Complete** the DMH Admission to a PRTF Medical Necessity Review Referral Form *(Exhibit 1),* and DMH HIPAA Form 3 – CYSD, Authorization to Use or Disclose Protected Information (Exhibit 2) and **submit** electronically to: PRTF.ReviewCommittee@dc.gov.

- Referrals that are illegible, incomplete, or do not have the required supporting documentation will not be reviewed by the PRTF Review Committee, and will be sent back to the referring party with further instructions.

(2) **Be available** during the Committee's scheduled review of referral to answer questions and provide additional information as needed.

(3) **Notify** PRTF Coordinator of the date of admission, name and address of PRTF when child or youth is placed in a PRTF.

(4) If the child or youth needs to stay in a PRTF past the time of the initial certification, **submit** electronically the DMH Continued Stay in a PRTF Medical Necessity Review Referral Form *(Exhibit 3)* to: PRTF.ReviewCommittee@dc.gov at least one (1) month prior to the end of the current certification period.

- If the referral is not submitted at least one (1) month prior to the end of the current certification period, the referral may not be reviewed prior to the expiration date of the initial medical necessity determination.
- Referrals sent after the expiration date of the current certification period will be reviewed only after all other pending referrals have been reviewed.
- The Department of Health Care Finance will not authorize Medicaid payment for a child or youth in a PRTF without a current medical necessity determination.

8b. **The PRTF Coordinator** shall:

(1) **Review** all referrals within two (2) business days of receipt for completeness and content.

- If additional information is needed, the PRTF Coordinator will request information from the referring entity with a specific due date for submission.

(2) For complete referrals, **Prepare and send** a written summary to PRTF Review Committee members.

(3) **Schedule** the child/youth referral packet for review by the Committee.

(4) **Coordinate** date and time for meeting, and **send** agenda to Committee members.

(5) **Attend, prepare, distribute** and **maintain** minutes of all Committee meetings.

(6) **Issue** written decision on medical necessity within 1-2 business days of Committee's determination to the referring entity and the Department of Health Care Finance (DHCF), and for continued stays, to the PRTF.

(7) **Maintain** a data base of all referrals received, and **maintain** a record of all actions taken on all referrals.

(8) **Notify** referring party of all pending expiration of certifications at least two (2) months prior to expiration of certification.

(9) **Compile** annual committee report (also see Section 7e above).

(10) **Maintain** roster of committee members.

9. **Appeals**. The referring entity or parent or legal guardian has the right to appeal a denial of medical necessity made by PRTF Review Committee by filing a written request for reconsideration.

9a. The appealing party will **submit** the Medical Necessity Determination Appeal Request Form (Exhibit 4) with supporting documentation to PRTF.ReviewCommittee@dc.gov within ten (10) business days of the date of the letter of the DMH denial of medical necessity.

9b. The DMH Program Manager for PRTF Diversion, Technical Assistance and Coaching for Children's Mental Health or designee will:

- **ensure** that the appeal is complete, including all documents (clinical notes and evaluations on the youth) in DMH possession.
- **submit** the appeal to an independent reviewer (a board certified child and adolescent psychiatrist who is contracted by DMH for this purpose) within one (1) business day of verifying a complete packet.
- **send** a copy to the DMH Chief Clinical Officer.

9c. The Independent Reviewer will **submit** a recommendation on medical necessity and length of stay, if applicable, based on a review of all submitted materials, within seven (7) business days of receipt of the appeal, to the DMH Chief Clinical Officer.

9d. The DMH Chief Clinical Officer will:

- **make** a determination within seven (7) business days of receipt of the recommendation from the independent reviewer;
- **send** the written determination to the PRTF Coordinator, who will disseminate the determination letter to all appropriate parties within one (1) business day of receipt (appealing party; Associate Chief Clinical Officer for Children and Youth; and the Program Manager for PRTF Diversion, Technical Assistance and Coaching for Children's Mental Health).

9e. If the appealing party is not satisfied with the written determination rendered by the DMH Chief Clinical Officer, the determination may be appealed to the Office of Administrative Hearings (OAH) or the Office of the Health Care Ombudsman and Bill of Rights for a fair hearing within ten (10) business days of the date of the determination letter.

10. **Confidentiality**. The PRTF Review Committee is subject to all requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Mental Health Information Act (MHIA).

11. **Inquiries**. Questions regarding this process may be directed to the DMH PRTF Coordinator or the Associate Chief Clinical Officer for Children and Youth.

12. **Related References**.
DMH Policy 300.5A, Maintaining Children and Youth in Their Homes
DMH Policy 340.10, High Fidelity Wraparound Care Planning Process
DMH Policy 340.11, Child/Youth and Family Teaming

13. **Exhibits**.
Exhibit 1 - DMH Admission to a PRTF Medical Necessity Review Referral Form
Exhibit 2 - DMH HIPAA Form 3 – CYSD, Authorization to Use or Disclose Protected Information
Exhibit 3 - DMH Continued Stay in a PRTF Medical Necessity Review Referral Form
Exhibit 4 - DMH Medical Necessity Determination Appeal Request Form

Approved By:

Stephen T. Baron
Director, DMH

(Signature) **(Date)**

DMH Policy 200.7
Exhibit 1 - 8a(1)

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Mental Health
Admission to a Psychiatric Residential Treatment Facility
Medical Necessity Review Referral Form

Every child/youth who is referred for review of medical necessity for psychiatric residential level of care should be a part of an ongoing family-driven team-based process. The team should consider the strengths and needs of the child/youth and the family in order to determine what supports and services would meet the needs of the child/youth. After multiple meetings and attempts at community-based services, if the team comes to a consensus that psychiatric residential treatment would best meet the needs of the child/youth, then this referral form should be completed and submitted to DMH.

1.) PLEASE COMPLETE THE REFERAL FORM AND AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION (SEE THE ATTACHED DMH HIPAA-FORM 3- CYSD). SUBMIT THESE WITH ALL OTHER SUPPORTING DOCUMENTATION AS LISTED ON PAGE 2.

2.) REFERRALS WHICH ARE ILLEGIBLE, INCOMPLETE, OR DO NOT HAVE REQUIRED SUPPORTING DOCUMENTATION WILL NOT BE REVIEWED BY THE PRTF REVIEW COMMITTEE. **IF THE REFERRAL PACKET IS INCOMPLETE, IT WILL BE SENT BACK TO THE REFERRING PARTY WITH FURTHER INSTRUCTIONS.**

3.) THE REFERRAL FORM AND ALL SUPPORTING DOCUMENTATION SHOULD BE SENT ELECTRONICALLY TO PRTF.REVIEWCOMMITTEE@DC.GOV. IF YOU NEED TO SEND THE DOCUMENTATION BY AN ALTERNATIVE METHOD, PLEASE CONTACT THE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) COORDINATOR AT 202- 673-3451.

4.) ONCE A REFERRAL PACKET IS RECEIVED, THE PRTF COORDINATOR WILL REVIEW THE PACKET FOR COMPLETENESS. BASED ON THE INITIAL REVIEW OF THE PACKET, THE COORDINATOR MAY REQUEST ADDITIONAL INFORMATION FROM THE REFERRING PARTY WHICH MUST BE PROVIDED WITHIN A SPECIFIED DUE DATE. THE COORDINATOR WILL THEN PROVIDE A CASE SUMMARY TO THE PRTF REVIEW COMMITTEE.

5.) UNLESS ADDITIONAL, ESSENTIAL INFORMATION IS REQUIRED TO MAKE A DETERMINATION, THE PRTF REVIEW COMMITTEE WILL REVIEW THE CASE AND MAKE A MEDICAL NECESSITY DETERMINATION.

6.) WITHIN 1-2 BUSINESS DAYS OF THE DETERMINATION, THE PRTF COORDINATOR WILL PROVIDE THE WRITTEN DETERMINATION TO THE REFERRING PARTY WITH ANY ADDITIONAL RECOMMENDATIONS MADE BY THE REVIEW COMMITTEE, AND PROVIDE A COPY TO THE DEPARTMENT OF HEALTH CARE FINANCE (DHCF).

IF THERE ARE ANY QUESTIONS REGARDING THIS PROCESS,
PLEASE CONTACT THE PRTF COORDINATOR AT 202-673-3451.

BELOW IS A LIST OF REQUIRED SUPPORTING DOCUMENTATION FOR THIS REFERRAL FOR REVIEW OF MEDICAL NECESSITY FOR PRTF.

Please check all that are included in the referral packet.

	DMH Medical Necessity Review Referral Form
	Authorization to Use or Disclose Protected Information (Use DMH-HIPAA FORM-3-CYSD)
	Parent/Caregiver **Authorization for Medical Necessity Review** for Psychiatric Residential Treatment (page 8 of referral)
	All **Psychiatric Evaluations** (within last year)
	All **Psychological Evaluations** (within last 2 years)
	All **Psycho-educational Evaluations** (within last 2 years)
	Diagnostic Assessment (completed within last year, if Psychiatric and/or Psychological Evaluations are not available)
	Treatment Plan and Discharge Recommendations (if youth is in a facility or hospital)
	Discharge Summaries from last 2 Hospitalizations
	Psychosocial Evaluation/Summary
	Social Study from Court Social Services (CSS)
	Recent Court Reports (must include description of any recent offenses, judge, attorney, defense attorney)
	Current Plan of Care or Team Meeting Notes over last 6 months (including sign-in sheets)
	Individualized Education Program (if applicable)
	Any other information relevant to this review **(i.e., 504 plan, recent progress notes, other evaluations, etc.)**

Referral Packet completed by (print): _____
Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

By signing below, I am certifying that the District agency/entity clinical team working with this child/youth believes that he/she meets medical necessity and this referral includes all of the above required documentation for this review:

Referring Agency Representative (print): _____
Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

Supervisor (print): _____
Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

Organization/Agency Affiliation: _____

PRTF Referral Form

Referred Youth's Information

Name (Last, First, Middle Initial):	Date of Birth:	Gender: □ Male □ Female
Address: (Current address, city, state, zip code)		Phone #:
Primary Language Spoken:		Secondary Language (if any):
□ The family reads and speaks English at home		□ Family speaks a different language at home:
The family needs an interpreter: □ Yes □ No		If different language, please list:
Medicaid Eligible: □ Yes □ No □ TBD	If, yes, please provide Medicaid #:	
	Check One: □ Fee For Service □Managed Care □ HSCSN	

Race/Ethnicity: (If Hispanic/Latino, choose from Section B; all others, choose from Section A)

Section A:	**Section B:**
□ American Indian/Alaska Native	□ Mexican
□ Asian	□ Puerto Rican
□ Black or African American	□ Cuban
□ Native Hawaiian or Other Pacific Islands	□ Dominican
□ White	□ Central American
□ Biracial (Specify):	□ South American
□ Other (Specify):	□ Other (Specify)

Parent Information (If parents are separated, include information for both parents)

Mother's Name: (Last, First, Middle Initial)		
Address: (Home address, city, state, zip code)		
Home Phone #:	Work Phone #:	Other Phone #:
Email Address:	Best Time To Call:	
Primary Language Spoken:	Secondary Language (if any):	
Father's Name: (Last, First, Middle Initial)		
Address: (Home address, city, state, zip code)		
Home Phone #:	Work Phone #:	Other Phone #:
Email Address:	Best Time To Call:	
Primary Language Spoken:	Secondary Language (if any):	

Primary Caregiver/Legal Guardian Information (if not parent)

Name: (Last, First, Middle Initial)		Relationship to Child/Youth:
Address: (Home address, city, state, zip code)		
Home Phone #:	Work Phone #:	Other Phone #:
Email Address:	Best Time To Call:	
Primary Language Spoken:	Secondary Language (if any):	
Legal Guardian: □ Yes □ No If No, provide name:		

Other Important Contacts

If we cannot contact one of the parents or caregivers, please list the name of an additional involved contact person (e.g., grandparent, adult sibling, aunt/uncle):

Name:	Relationship to Youth:	Phone:
Name:	Relationship to Youth:	Phone:

Sibling Information (attach additional sheet as needed)

Name (First & Last)	Gender M/F	Date of Birth	Relationship to Youth	School/Grade	Current Residence

School Information

Local Education Agency (LEA): (for example, DCPS, Charter School, etc.)

School Name:

Current Academic Performance:		Grade Level:
□ Regular Education (specify accommodations, if any):	□ Special Education (attach Individualized Education Program) □ Primary Disability Category:	□ Other (specify):

Is the attendance of the youth an issue/concern? □ Yes □ No

If Yes, what has been done to address it:

Teaming

Team Meeting Notes or Plan of Care Attached □ Yes □ No

Has the team met routinely and adjusted the Plan of Care? □ Yes □ No If Yes, how often:

If No, please explain:

Teaming/ Care Coordination provided by:

□ DC Choices Wraparound Process

□ Far Southeast Collaborative Child and Family Teaming □ GA Avenue Collaborative Child and Family Teaming

□ DYRS Youth and Family Teaming □ CSS Family Group Conferencing

□ Other (specify):

Name of Team Facilitator/Care Coordinator:

Is the team in consensus about referring this youth to PRTF? □ Yes □ No

If No, identify the parties who disagree and why:

Current System Involvement and Team Members (Select all that apply)			
	Contact Person	Phone #	Email
□ Court Social Services (Probation)			
□ Department of Youth Rehabilitation Services			
□ Education			
□ Child and Family Services Agency			
Parents' Rights Terminated: □Yes □ No			
□ Special Education			
□ Mental Health Provider (agency name:)			
□ Specialty Mental Health Provider: (For example, CBI, MST, FFT, private therapist)			
□ Hospital			
□ Physical Health Care Agency/Clinic/Provider			
□ Substance Abuse Agency/Clinic/Provider			
□ Other (Please specify)			
□ Other (Please specify)			

Current Living Situation of Youth	
□ Two Parent Biological Family	□ Therapeutic Group Home
□ One Parent Biological Family	□ Youth Shelter House
□ Two Parent Adoptive Family	□ Runaway/Homeless
□ One Parent Adoptive Family	□ Detention: □ Youth Services Center □ New Beginnings
□ Grandparent(s)	□ Residential Treatment Center Name:
□ Other Relative's Home	□ Psychiatric Residential Treatment Facility Name:
□ Other Non-Relative's Home	□ Acute Care Inpatient Hospital:
□ Traditional Foster Care	□ Sub-Acute Care Inpatient Hospital:
□ Therapeutic Foster Care	□ Other specify:
□ Traditional Group Home	
Anticipated discharge date from above (If applicable):	

Out of Home Placement Due to Family Court:		
Is placement related to Child Welfare?	□ Yes	□ No
Is placement related to Juvenile Justice?	□ Yes	□ No

Family Court Involvement:
Next Court Date:
Type of Hearing:
Name of Judge:

During the Past 6 Months, was the Youth the Enrollee/Recipient of any of the Following? (Select all that apply)
□ Medicaid (Check one) □ Fee For Service □ Managed Care □ Health Services for Children with Special Needs
□ TANF (public assistance): □ Yes □ No □ Private Insurance (specify):
□ Social Security Disability Income & Amount (SSI Benefits): _____

DSM Diagnosis Source (provided within last 12 months)		
Which professional source made the diagnosis as indicated in the following information below?		
□ Child Psychiatrist	□ Licensed Clinical Social Worker	□ Child Psychologist
□ General Psychiatrist	□ Nurse Practitioner	□ General Psychologist
□ Licensed Professional Counselor	□ Other: _____	
Name of Clinician:	Date of Diagnosis:	

DSM Diagnosis Information	
AXIS I: CLINICAL DISORDERS (*Please list Axis 1 Primary Diagnosis first.*)	
AXIS II: PERSONALITY DISORDERS, MENTAL RETARDATION (*If any*)	
AXIS III: GENERAL MEDICAL CONDITIONS (*If any*)	
AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS (*Select all that apply*)	
□ Problems with primary support group	□ Economic problems
□ Problems related to the social environment	□ Problems with access to health care services
□ Educational problems	□ Occupational problems
□ Other psychosocial and environmental problems	□ Housing problems
□ Problems related to interaction with the legal system/crime	
AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING (GAF):	

What are the problems within last 6 months that led to this referral for PRTF? **Check** and **Circle** all that apply
□ Suicide-related problems (including suicide ideation, suicide attempt, self-injury)
□ Depression-related problems (including major depression, dysthymia, sleep disorders, somatic complaints)
□ Anxiety-related problems (including fears and phobias, generalized anxiety, social avoidance, obsessive-compulsive behavior, post-traumatic stress disorder)
□ Hyperactive and attention-related problems (including hyperactive, impulsive, attention difficulties)
□ Conduct/delinquency-related problems (including physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact)
□ Substance use, abuse, and dependence-related problems
□ Adjustment-related problems (including changes in behaviors or emotions in reaction to a significant life stress)
□ Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors)
□ Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior)
□ Specific developmental disabilities (including enuresis, encopresis, expressive or receptive speech and language delay)
□ Learning Disabilities
□ School performance problems not related to learning disabilities
□ Eating Disorders (anorexia, bulimia, obesity)
□ Trauma (community violence, school violence, complex trauma, domestic violence, medical trauma, natural disasters, neglect, physical abuse, refugee and war zone trauma, sexual abuse, terrorism, traumatic grief)
□ Other Problems (Please specify):

CRITICAL INFORMATION FOR ELIGIBILITY

IMPORTANT: Eligibility factors are largely based on risk of out-of-home placement or hospitalization. Be explicit and detailed including the level of severity and frequency of the behaviors. *DC PRTF Admission criteria listed on page 9 of this referral form should be addressed here. Add additional pages if necessary.*

At-Home: (examples: safety concerns for youth and/or family, rebellious, curfew violations, physical aggression, trauma)
In School: (examples: attendance, suspension, altercations, weapons)
In Community: (examples: involvement with Crisis Services, Juvenile Justice involvement, substance abuse)

Services Received within Last Year to Attempt to Stabilize Youth :

Please select all that apply and add additional pages regarding outcomes if necessary

	Agency/Individual	Dates of Service
□ Inpatient Acute Hospitalization (s)		
□ Inpatient Sub-acute Hospitalization (s)		
□ Psychiatric Residential Treatment **(any time within last 5yrs)**		
□ Individual Therapy (frequency:)		
□ Family Therapy (frequency:)		
□ Community Support		
□ Community Based Intervention		
□ Multi-Systemic Therapy		
□ Functional Family Therapy		
□ Trauma-Focused Cognitive Behavior Therapy		
□ School Mental Health Services (specify type:)		
□ Substance Abuse Treatment		
□ Day Treatment		
□ One-on-One Staff (frequency/setting:)		
□ Special Education Services (IEP)		
□ Other (specify)		
□ Other (specify)		

Justification for PRTF Level of Care

Indicate why lower levels of service have not been successful in stabilizing this youth and why he/she requires PRTF to meet her/her needs.

Expectations from PRTF

Please identify the goals of treatment in PRTF, the anticipated length of stay in PRTF, and anticipated plans upon discharge.

Goals:

Anticipated Length of Stay:

Anticipated Discharge Plans:

Youth & Family Strengths

Describe youth and family **strengths** that will assist in keeping the youth at home and within the community; or, what strengths will assist in the successful return of the youth from placement.

To Be Completed By Parent/Legal Guardian Only:

The Department of Mental Health recognizes that families have a voice and choice during the process for reviewing for medical necessity for treatment in a Psychiatric Residential Treatment Facility (PRTF). I, as the parent/caregiver, understand that my family's strengths and needs were identified prior to this review. I will continue to work with my child/family team to help determine what will work best for my child and family.

Name of Parent or Legal Guardian (Print): _____

Signature: _____ Date: _____

District of Columbia PRTF Admission Criteria

Beneficiaries are considered a candidate for this level of care if they present with items 1-9:

1) The child/adolescent/young adult must be between the ages of 5 and 21 years old;
2) Presence of a severe emotional disturbance as evidenced by all of the following:
   a) An Axis I primary diagnosis provided by a licensed professional working within his/her scope of practice; and
   b) Documented history of multiple unsuccessful treatment approaches which include receiving a wide range of modalities (i.e. in-home and community based services, acute psychiatric hospitalizations, psychiatric medication intervention, etc.) at least within the past year resulting in poor outcomes; and
3) Maladaptive behaviors are expected to continue for six (6) months or longer without treatment;
4) Clinical documentation indicating current and consistent severe functional impairment within the past six (6) months in multiple life domains that include two or more of the following:
   a) Recurrent suicidal/homicidal ideation without current intent, plan or means;
   b) Pattern of absconding from primary care taker and school placement;
   c) Impulsivity and/or physical aggression;
   d) Problematic sexual behaviors, such as:
      - Sexually reactive behavior, or
      - Sex offending behavior;
   e) Persistent substance abuse/use regardless of continued or increasing negatively associated consequences and multiple treatment attempts;
   f) Psychosis that has not responded favorable to in-home and community-based supports and services; and/or
   g) Persistent maladaptive behaviors that are related to a mood disorder.
5) Disturbances/behaviors/symptoms are such that treatment cannot be successfully provided in a lower level of care.
6) The child/adolescent/young adult has sufficient cognitive capacity to respond to active acute and time limited psychological treatment and intervention.
7) The child/adolescent/young adult requires a time limited period for stabilization and community re-integration.
8) The child/adolescent's/young adult's behavior or symptoms, as evidenced by the initial assessment and treatment plan, are likely to respond to or are responding to active treatment.
9) A Child and Family Teaming process where the child/youth, family members, natural/informal supports, community-based mental health providers, and other professional supports have been involved in the intensive in-home and community-based care planning process and the decision for a referral to review for a PRTF Level of Care. Included in the Child and Family Teaming process are multiple meetings over a period of time where there has been tracking and adjusting of the in-home and community-based Plan of Care, outreach and engagement strategies with family, if needed, have occurred, and a mix of traditional and non-traditional supports have been included in the Plan of Care.

Authorization
to Use or Disclose Protected Information
Department of Mental Health (DMH)
Child and Youth Services Division (CYSD)

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to District of Columbia children or youth with mental health issues. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations.

I hereby give permission to use and disclose health, mental health, alcohol and drug, education, child welfare, and juvenile justice records as described below.

The person whose information may be used or disclosed is:

Name of child or youth (type or print) _____ eCura # (if applicable)

Address _____ Date of Birth _____

City/State/Zip Code _____ Other name(s) used

The information that may be used or disclosed includes: (check all that apply)

___ Health Records
___ Mental Health Records
___ Alcohol/Drug Records
___ School or Education Records
___ Child Welfare Records
___ Juvenile Justice Records
___ Other records (list) _____
___ All of the records listed above

This information may be disclosed by:

___ Any person or organization that possesses the information to be disclosed as a result of providing health, education, child welfare, juvenile justice, or other related services.
___ The organizations listed on Page 4
___ The following persons or organizations that provide services to me:

This information may be disclosed to:

___ Any person or organization that needs the information to provide services to the child/youth who is the subject of the record; pay for those services; or engage in quality assurance or other health care operations related to the child/youth as a result of providing health, education, child welfare, juvenile justice, or other related services.
___ The organizations listed on Page 4
___ The following persons or organizations:

The purposes for which this information may be used and disclosed include:

Evaluation of eligibility to participate in a child and family teaming process or review for medical necessity for Psychiatric Residential Treatment Facility (PRTF);
Delivery of services as a result of providing health, education, child welfare, juvenile justice, or other related services, including care coordination and case management;
Payment for such services; and
Health care operations, such as quality assurance.
Other, List: _____

EXPIRATION: This authorization will expire 365 days from the date this form was signed unless one or both of the following is checked, in which case it will expire on the earliest occurrence.

☐ On _____/_____/_____ (cannot be more than 365 days from the date of this form).

☐ When the following happens: _____
(must relate to the consumer or to the purpose of this request, e.g., discharge from PRTF, court case closed).

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice to the organization that was authorized to release this information. I understand that revocation of this authorization will *not* affect any action by the organization that was authorized to release this information before it received my written notice of revocation. I understand that my right to revoke this authorization may be limited if the purpose of this authorization involves applying for health or life insurance.

I revoke this authorization effective _____/___/_____

_____
Signature of child/youth if age of 14, or parent or legal guardian and relationship to the child/youth

UNAUTHORIZED DISCLOSURE:

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization, or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

I understand that this information cannot legally be redisclosed by the person or organization that received it without my authorization.

OTHER RIGHTS:

I understand that I have the right to inspect my record of protected health information. I also understand that I cannot be denied enrollment or services if I decide not to sign this form. However, I may not be able to apply for benefits or renewal of benefits that would help pay for these services.

AUTHORITY TO ACT ON BEHALF OF CHILD OR YOUTH (check one):

Parent _____ Legal guardian _____ **(for legal guardian, must provide the guardianship order)**

_____Custodial agency representative, if parental rights are terminated.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

I, _____, understand that, by signing this form, I am authorizing the use and/or disclosure of the protected health information identified above.

_____ Date: _____
Signature

_____
Print or type full name

Address: _____

Phone Number: _____

SIGNATURE OF MINOR:

If the consumer is at least 14 years of age, but under 18 years of age, this authorization is not valid unless the child/youth signs in addition to the parent/legal guardian/agency representative. A minor of any age may authorize disclosure based on his or her signature alone, if (1) he or she is an emancipated minor, or (2) he or she is receiving treatment or services without a parent or legal guardian giving consent.

_____ Date: _____
Signature of Minor

_____ Date of Birth: _____
Print or type full name

Address: _____

Phone Number: _____

TO THE RECORDS CUSTODIAN:

1. Provide a copy of this authorization to the child if age 14 or parent or legal guardian.
2. Put signed original in the child/youth's clinical record.
3. Send a copy of this form with the information to be disclosed.

This permission to use or disclose protected information applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to District of Columbia children and youth.

___ Department of Mental Health (DMH)

___ Child and Family Services (CFSA)

___ Department of Youth Rehabilitation Services (DYRS)

___ Court Social Services (CSS)

___ DC Public Schools (DCPS)

___ Office of the State Superintendent of Education (OSSE)

___ Managed Care Organization (MCO) that provides services to the child or youth: _____
(Name)

___ Contracted mental health providers that provide services or supports to the child or youth (e.g., child's CSA, subproviders and specialty providers, DC choices)

___ Addiction Prevention and Recovery Administration (APRA)

___ Psychiatric Institute of Washington (PIW)

___ Children's National Medical Center (CNMC)

___ Psychiatric Residential Treatment Facility (PRTF) where child is placed

___ Other, list below:

_____

_____

DMH Policy 200.7
Exhibit 3 - 8a(4)

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Mental Health
Continued Stay in a Psychiatric Residential Treatment Facility
Medical Necessity Review Referral Form

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1) REFERRALS FOR CONTINUED STAY IN A PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) MUST BE RECEIVED FROM THE MONITOR OR PLACING AGENCY **AT LEAST ONE (1) MONTH PRIOR** TO THE END OF THE CURRENT CERTIFICATION PERIOD. **IF NOT, THE REFERRAL MAY NOT BE REVIEWED PRIOR TO THE EXPIRATION DATE.**

2) **REFERRALS SENT AFTER THE EXPIRATION DATE OF THE CURRENT CERTIFICATION PERIOD WILL BE REVIEWED ONLY AFTER ALL OTHER PENDING REFERRALS HAVE BEEN REVIEWED.**
   - ***The Department of Health Care Finance (DHCF) will not authorize Medicaid payment for a child or youth in a PRTF without a current medical necessity determination.***

3) REFERRALS WHICH ARE ILLEGIBLE, INCOMPLETE, OR DO NOT HAVE REQUIRED SUPPORTING DOCUMENTATION WILL NOT BE REVIEWED BY THE PRTF MEDICAL NECESSITY REVIEW COMMITTEE. **IF THE REFERRAL PACKET IS INCOMPLETE, IT WILL BE SENT BACK TO THE REFERRING PARTY WITH FURTHER INSTRUCTIONS.**

4) PLEASE COMPLETE THE REFERAL FORM AND AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION (DMH HIPAA-FORM 3- CYSD). SUBMIT THESE WITH ALL OTHER SUPPORTING DOCUMENTATION AS LISTED ON PAGE 5.

5) THE REFERRAL FORM AND ALL SUPPORTING DOCUMENTATION SHOULD BE SENT ELECTRONICALLY TO PRTF.REVIEWCOMMITTEE@DC.GOV. IF YOU NEED TO SEND THE DOCUMENTATION BY AN ALTERNATIVE METHOD, PLEASE CONTACT THE PRTF COORDINATOR AT 202-673-3451.

6) ONCE A REFERRAL PACKET IS RECEIVED, THE PRTF COORDINATOR WILL REVIEW THE PACKET FOR (1) COMPLETENESS AND (2) CONTENT. THE COORDINATOR MAY REQUEST ADDITIONAL INFORMATION FROM THE REFERRING AGENCY WHICH MUST BE PROVIDED WITHIN A SPECIFIED DUE DATE. THE COORDINATOR WILL THEN PROVIDE A CASE SUMMARY TO THE PRTF REVIEW COMMITTEE.

7) UNLESS ADDITIONAL, ESSENTIAL INFORMATION IS REQUIRED TO MAKE A DETERMINATION, THE PRTF REVIEW COMMITTEE WILL REVIEW THE CASE AND MAKE A DETERMINATION.

8) WITHIN 1-2 BUSINESS DAYS OF THE DETERMINATION, THE PRTF COORDINATOR WILL PROVIDE THE WRITTEN DETERMINATION WITH ANY ADDITIONAL RECOMMENDATIONS MADE BY THE REVIEW COMMITTEE TO THE REFERRING PARTY, DHCF, AND THE PRTF.

IF THERE ARE ANY QUESTIONS REGARDING THIS PROCESS,
PLEASE CONTACT THE PRTF COORDINATOR AT 202-673-3451.

Continued Stay in a PRTF
Medical Necessity Review Referral Form

Child/Youth Name: _____ DOB: _____

Provider/Facility: _____ Date of Admission: _____

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

Legal Guardian (if not parent) Name: _____
Phone: _____

Family Involvement in:
Treatment Planning ☐ Yes ☐ No (if no, indicate why): _____
_____

Family Therapy ☐ Yes ☐ No (if no, indicate why): _____
_____

Agency Involvement (please check all that apply):

- ☐ Child and Family Services Agency
- ☐ Court Social Services
- ☐ Department of Mental Health
- ☐ Department of Youth Rehabilitation Services
- ☐ Office of the State Superintendent of Education
- ☐ Local Education Agency (for example: DCPS, Charter School, etc.): _____
- ☐ Public Defender Services
- ☐ Other (please specify): _____

Name of Family Court Judge(s): (if applicable) _____

Next Court Date and Type of Hearing: (if applicable) _____

Court-Order for PRTF? ☐ Yes ☐ No
(If yes, court order must accompany referral packet)

Education-Related Hearing Officer Determination (HOD) for PRTF ☐ Yes ☐ No
(If yes, HOD must accompany referral packet)

Date of Most Recent Treatment Team Meeting: _____

Time-length of last Medical Necessity Certification: ___ months

End Date of Last Certification: _____

Projected Discharge Date: _____

Additional certification time recommended by the Treatment Team: _____

The information provided below is from the following sources (as applicable):

Telephone interview with _____ Date: _____
Name Title

Telephone interview with _____ Date: _____
Name Title

Psychiatric Evaluation completed by _____, M.D. Date: _____

Comprehensive Individual Plans of Care for these Dates: _____

Notes of Progress (i.e., either summaries or notes from individual therapy, family therapy, etc.):

_____ Date(s): _____
Name Title

_____ Date(s): _____
Name Title

Other (if applicable, please specify with dates):

_____

_____

_____

Diagnosis(es) according to most recent treatment plan from the PRTF:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: GAF

Current Medications (including dose and schedule of administration):

_____

_____

_____

_____

_____

Facility's response to PRTF Committee's recommendation on previous Letter of Certification:

_____

_____

_____

PRTF Continued Stay Criteria:

Using the Continued Stay Criteria below, please provide *detailed justification for each item below* (please include separate pages to address this section).

1) Admission criteria continue to be met. *(Please address each of the PRTF Admission Criteria as outlined on page 6.)*

2) Caregivers (parents/legal guardian and foster parents), and other family members, are actively involved in their child's treatment and discharge planning, and are actively involved in their child's treatment as outlined in the treatment plan that is based on the family's needs.

3) The legal custodian/lead agency is actively involved in the child's treatment and discharge planning, and is actively involved in their child's treatment as outlined in the treatment plan that is based on the family's needs.

4) Treatment is individualized and documentation of needed adjustments are made.

5) Symptoms/behaviors are reasonably expected to improve with continued treatment so that the child/youth/young adult may be transitioned to a lower less restrictive level of care. *(Include evidence of treatment effectiveness. For example, indicate observable behaviors which have improved. Also include efforts towards discharge planning.)*

All of the following documents must be included for a complete referral packet
(Please check each box to indicate that these documents are included with this referral):

- ☐ Completed Referral Form with Justification for Criteria Completed
- ☐ Copy of previous medical necessity determination Level of Care (LOC) letter
- ☐ Authorization to Use or Disclose Protected Health Information signed by parent/legal guardian (Use the attached DMH HIPAA Form 3-CYSD)
- ☐ All Psychiatric Evaluations (within the last year)
- ☐ Last 2 Treatment Plans/Reviews/Summaries
- ☐ Summary of Progress in Therapy
- ☐ Court Order for PRTF (if applicable)
- ☐ All Psychological Evaluations (within the last two years)
- ☐ All Psycho-educational Evaluations (within the last two years)
- ☐ Most recent Individualized Education Program (IEP), if applicable
- ☐ Most recent Social Study completed by Court Social Services (CSS), if applicable

Referral Packet completed by (print): _____
Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

By signing below, I am certifying that the District agency/entity clinical team working with this child/youth believes that he/she meets medical necessity and this referral includes all of the above required documentation for this review:

Referring Agency Representative (print): _____
Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

Supervisor (print): _____
Name/Title

Signature: _____ Date: _____

Email: _____ Phone: _____

Organization/Agency Affiliation: _____

PRTF Admission Criteria

Beneficiaries are considered a candidate for this level of care if they present with items 1-9:

1) The child/adolescent/young adult must be between the ages of 5 and 21 years old;
2) Presence of a severe emotional disturbance as evidenced by all of the following:
   a) An Axis I primary diagnosis provided by a licensed professional working within his/her scope of practice; and
   b) Documented history of multiple unsuccessful treatment approaches which include receiving a wide range of modalities (i.e. in-home and community based services, acute psychiatric hospitalizations, psychiatric medication intervention, etc.) at least within the past year resulting in poor outcomes; and
3) Maladaptive behaviors are expected to continue for six (6) months or longer without treatment;
4) Clinical documentation indicating current and consistent severe functional impairment within the past six (6) months in multiple life domains that include two or more of the following:
   a) Recurrent suicidal/homicidal ideation without current intent, plan or means;
   b) Pattern of absconding from primary care taker and school placement;
   c) Impulsivity and/or physical aggression;
   d) Problematic sexual behaviors, such as:
      - Sexually reactive behavior, or
      - Sex offending behavior;
   e) Persistent substance abuse/use regardless of continued or increasing negatively associated consequences and multiple treatment attempts;
   f) Psychosis that has not responded favorable to in-home and community-based supports and services; and/or
   g) Persistent maladaptive behaviors that are related to a mood disorder.
5) Disturbances/behaviors/symptoms are such that treatment cannot be successfully provided in a lower level of care.
6) The child/adolescent/young adult has sufficient cognitive capacity to respond to active acute and time limited psychological treatment and intervention.
7) The child/adolescent/young adult requires a time limited period for stabilization and community re-integration.
8) The child/adolescent's/young adult's behavior or symptoms, as evidenced by the initial assessment and treatment plan, are likely to respond to or are responding to active treatment.
9) A Child and Family Teaming process where the child/youth, family members, natural/informal supports, community-based mental health providers, and other professional supports have been involved in the intensive in-home and community-based care planning process and the decision for a referral to review for a PRTF Level of Care. Included in the Child and Family Teaming process are multiple meetings over a period of time where there has been tracking and adjusting of the in-home and community-based Plan of Care, outreach and engagement strategies with family, if needed, have occurred, and a mix of traditional and non-traditional supports have been included in the Plan of Care.

DEPARTMENT OF MENTAL HEALTH

MEDICAL NECESSITY DETERMINATION
APPEAL REQUEST FORM

The Department of Mental Health (DMH) provides an opportunity for an Appeal of a denial of medical necessity certification for Psychiatric Residential Treatment Facility (PRTF) placement.

1. **An appeal request form with supporting documentation must be sent to: prtf.reviewcommittee@dc.gov within ten (10) business days of the date of the DMH Denial of Medical Necessity letter.**

2. If you need to fax the documentation, please fax the information to 202-673-7502 to the attention of the Child and Youth Services Division Program Assistant and titled as "LOC Appeal".

3. **Upon emailing or faxing the appeal request, call 202-671-2901 to confirm receipt.**

4. The written request for an appeal must include signature of the appealing party and the date of submission.

5. The appeal request form should include a clear, brief statement of appeal with factual support (clinical and other documentation), if appropriate, and an explanation of why the appealing party disagrees with the determination that was made.

6. The appeal packet should also include a copy of the recent child and family team's Individualized Plan of Care and a copy of the medical necessity determination being appealed.

7. The Program Manager for PRTF Diversion, Technical Assistance, and Coaching for Children's Mental Health, or designee, will ensure that the appeal is complete, including all documents (clinical notes and evaluations on the youth) in DMH possession.

8. The Program Manager for PRTF Diversion, Technical Assistance, and Coaching for Children's Mental Health, or designee, will submit the appeal to an independent reviewer (a board certified child and adolescent psychiatrist contracted by DMH for this purpose) within one (1) business day of verifying a complete packet. A copy will also be sent to the DMH Chief Clinical Officer.

9. The independent reviewer will submit a recommendation on medical necessity and length of stay, if applicable, based on a review of all submitted materials, within (7) seven business days of receipt of the appeal and will communicate that recommendation (electronically) to the DMH Chief Clinical Officer. The independent reviewer will mail the hard copy of the appeal recommendation to the DMH Chief Clinical Officer.

10. **The DMH Chief Clinical Officer will make a determination within seven (7) business days of receiving the recommendation from the independent reviewer.** Once the determination has been made, the Office of the Chief Clinical Officer will send the written determination to the PRTF Coordinator, who will send the determination letter to the appealing party; the Associate Chief Clinical Officer for Children and Youth; and the Program Manager for PRTF Diversion, Technical Assistance and Coaching for Children's Mental Health within one (1) business day of receipt.

11. If the appealing party is not satisfied with the written determination rendered by the DMH Chief Clinical Officer, the determination may be appealed to the Office of Administrative Hearings (OAH) or the Office of the Health Care Ombudsman and Bill of Rights for a fair hearing within ten (10) business days of the date of the determination letter.

DMH MEDICAL NECESSITY DETERMINATION APPEAL REQUEST FORM

Name of Child/Youth: DOB: Next Court Date: Judge: Date of last child and family team meeting: Date of medical necessity determination: Appellant's relationship to child: *(if not legal guardian, must supply proof that legal guardian supports appeal)*	Daytime Telephone Number of Appealing Party Name, Agency, Address and Email of Appealing Party

SPECIFIC REASON(S) FOR APPEAL:
Explain why you disagree with the DMH Denial of PRTF Medical Necessity determination. Include any behavior, treatment or placement records that post-date the medical necessity determination or that were not previously included in the initial packet.

Please include contact information of any interested parties (family members, service providers, guardian *ad litem*, etc.).

Describe attempts to fulfill the recommendations of the medical necessity determination, and why these attempts were unsuccessful. (Attach additional sheets if necessary)

Requestor's Name _____ **Agency** _____

Requester's Signature _____ **Date of Request** _____

Are the services of an interpreter required for any requested contacts? ☐ **Yes** ☐ **No**
If yes, what type _____

DEPARTMENT OF HEALTH CARE FINANCE

Q3. Please provide the Committee with the following for FY16 and to date in FY17:

a. A list of all employees who receive cell phones, personal digital assistants, or similar communication devices at agency expense;
b. A list of employees receiving bonuses, special pay, additional compensation, or hiring incentives in FY16 and to date in FY17 and the amount;
c. A list of travel expenses for FY16 and to date in FY17, arranged by employee; and
d. A list of all employees with a salary over $100,000.

Response:

The agency's responses are as follows:

a. For Question 3(a), please see Attachment 1 to Q3(a) for a list of 2016-2017 DHCF Communication Devices.

b. For Question 3(b), please see Attachment 2 to Q3(b) for Bonuses, Special Pay, Additional Compensation and Hiring Expenses in FY16 and FY17.

c. For Question 3(c), please see Attachments 3A and 3B to Q3(c) for FY16 and FY17 Travel Expenses.

d. For Question 3(d), please see Attachment 4 for a list of all employees with a salary of over $100,000.

DEPARTMENT OF HEALTH CARE FINANCE

Q5. Have any spending pressures been identified for FY17? If so, please provide a detailed narrative of the spending pressure, including any steps that are being taken to minimize its impact of the budget.

Response:

As of the first quarter, DHCF has not identified any FY 2017 spending pressures.

DEPARTMENT OF HEALTH CARE FINANCE

Q7. Please identify any reprogrammings received by or transferred from DHCF during FY16 and to date in FY17, and include a description of the purpose of the transfer and which DHCF programs, activities, and services were affected.

Response:

Please see Attachment 1 to Q7 for a list of reprogrammings received by, or transferred from, DHCF during FY16 and to date in FY17.

DEPARTMENT OF HEALTH CARE FINANCE

Q8. Please identify any intra-district transfers received by or transferred from DHCF during FY16 and to date in FY17, and include description as to the purpose of the transfer and which DHCF programs, activities, and services were affected.

Response:

Please see Attachment 1 to Q8 for a list of intra-district transfers received by, or transferred from, DHCF during FY16 and to date in FY17.

DEPARTMENT OF HEALTH CARE FINANCE

Q9. Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY16 and to date in FY17. Please include the following:

a. Revenue source name and code;
b. Description of the program that generates the funds;
c. Activity that the revenue in each special purpose revenue fund supports;
d. Total amount of funds generated by each source or program in FY16 and to date in FY17; and
e. FY16 and to date FY17 expenditure of funds, including purpose of expenditure.

Response:

Please see Attachment 1 to Q9 for a complete accounting of all of DHCF's Special Purpose Revenue Funds.

DEPARTMENT OF HEALTH CARE FINANCE

Q10. Please provide the following information for all grants awarded to DHCF during FY16 and to date in FY17:

a. Grant Number/Title;
b. Approved Budget Authority;
c. Expenditures;
d. Purpose of the grant;
e. Grant deliverables;
f. Grant outcomes, including grantee performance;
g. Any corrective actions taken or technical assistance provided;
h. Funding source;
i. Is the grant a result of federal health care reform;
j. DHCF program and activity supported by the grant; and
k. DHCF employee responsible for grant deliverables.

Response:

Please see Attachment 1 to Q10 for information on all grants awarded to DHCF during FY16 and FY17, to date.

DEPARTMENT OF HEALTH CARE FINANCE

Q11. For each grant lapse that occurred in FY 2016, please provide:

a. A detailed statement on why the lapse occurred;
b. Any corrective action taken by DHCF; and
c. Whether the funds were carried over into FY17.

Response:

Please see Attachment 1 to Q11 for a list of grant lapses.

DEPARTMENT OF HEALTH CARE FINANCE

Q12. Please provide DHCF's capital budgets for FY16 and FY17 and include the following information:

a. The amount budgeted and actually spent;
b. Impact on operating budget; and
c. Programs funded by the capital budget.

Response:

Please see Attachment 1 to Q12 for capital budget information.

DEPARTMENT OF HEALTH CARE FINANCE

Q13. Please provide DHCF's fixed costs budget and actual dollars spent for FY16 and to date in FY17, and include the following information:

a. Source of funding;
b. Narrative explanation for changes; and
c. Steps the agency has taken to identify inefficiencies and reduce costs.

Response:

Please see Attachment 1 to Question 13 for the agency's fixed costs budget.

DEPARTMENT OF HEALTH CARE FINANCE

Q18. Identify each District of Columbia agency and Public Charter School that submitted Medicaid claims in FY16 and FY17 to date, and include the following information:

a. The number and total dollar amount of claims filed per agency each month;
b. The number and total dollar amount of claims denied per agency each month;
c. Whether the agency uses a third party billing agent; and
d. Whether each agency has been integrated into the ASO and, if not, whether there are plans for the agencies to process claims through the ASO.

Response:

Please see Attachment to Q18 for the total dollar amount of claims filed and denied per agency each month.

The following agencies use third party billing agents:

- Public Chartered Schools – Billing is handled by the ASO
- Office of the State Superintendent (OSSE) – Billing is handled by the ASO
- DCPS – Billing is handled by the ASO
- DC Fire Dept – A third party agent (Zirmed) is handling their claiming
- DC Dept of Environment – Information is not available to determine if claims are handled by a third party agent.

The only agencies initially designated to onboard with the ASO were CFSA, DCPS, DCPCS and OSSE Transportation. Starting in FY17, OSSE Non-Publics and Early Intervention will be joining the ASO. Other agencies will be implemented on an as needed basis. Integration of DBH and FEMS into the ASO was not performed as they handle their own claiming to Medicaid through a third party billing agent. DYRS invoices through local dollars due to the nature of their beneficiaries, however integration into the ASO can be explored in the upcoming fiscal year.

DEPARTMENT OF HEALTH CARE FINANCE

Q19. Please describe, in detail, how DHCF's Quality Improvement Organization (QIO) monitored the performance and quality of care offered by the District's Medicaid providers, including any trends that were identified in FY16 and FY17, to date, any policy change recommendations, and any corrective action taken as a result thereof.

Response:

1. *Performance and Quality of Care Monitoring*

The Department of Health Care Finance (DHCF) contracts with Qualis Health, a Centers for Medicare and Medicaid Service (CMS) certified Quality Improvement Organization (QIO), to provide quality improvement activities. Qualis Health was the federally-designated QIO for the District during Fiscal Year 2016. Qualis provides utilization review and quality reviews for DHCF and receives requests to authorize services from various Fee for Service (FFS) Medicaid providers, including: Hospitals, Nursing Homes, Long Term Acute Care (LTAC) Hospitals, Rehabilitation Hospitals, Specialty Hospitals, Case Management Agencies, Durable Medical Equipment (DME) providers, Optical providers, and Physicians. Qualis also reviews requests for reconsideration for reductions and denials of Personal Care Aide (PCA) services. In FY16, Home Hospice and Home Care reviews were also added to the Qualis contract.

The QIO is responsible for reviewing and monitoring the information submitted by Medicaid providers and personal letters submitted by beneficiaries and physicians that submit requests for services, and monitors the information for quality of care concerns, fraud, waste, and abuse. If concerns arise, the QIO notifies the Contract Administrator (CA) for further clarification or investigation. The CA in turn notifies the Division of Program Integrity (PI) at DHCF.

2. *Trends in FY16 and FY17, to date*

In FY16, Qualis identified an area of concern pertaining to nursing homes that resulted in a policy change at DHCF. Qualis uncovered several cases where beneficiary information on paper did not coincide with the actual physical condition of the beneficiary, and had been inflated to obtain admission to the facility. Because Qualis was able to identify this issue, DHCF will implement a face-to-face assessment for admission to a nursing home in 3rd quarter FY17.

Additionally, Qualis found that several NH's were receiving payments despite a lack of appropriate authorization for nursing home placement. While it appears that the number of individuals improperly placed was small, Qualis was able to determine that residents who were properly placed initially – but whose health later improved – still remained in nursing homes that exceeded the level of care that they required. To remedy this issue, in FY16, DHCF implemented a policy that requires a Level of Care (LOC) approval notice to accompany a recertification packet before the Economic Security Administration (ESA) issues a recertification. Certification takes place before an individual is placed in a nursing home and that person is recertified again after 30 days, six months, and then annually thereafter. This

ensures that the Nursing Homes are receiving reimbursement for residents who are deemed appropriate for this long term care benefit.

As a result of this new policy, Qualis found that approximately 25 beneficiaries did not meet a nursing home level of care in FY16. DHCF and DCOA work together to transition residents to a suitable environment whenever a resident is decertified by Qualis.

DEPARTMENT OF HEALTH CARE FINANCE

Q20: With respect to the MMIS system, please provide the following information:

a. Fraudulent trends identified by eFads;
b. A list of the providers that have been placed on review due to fraudulent activity; and
c. A list of the providers that have been placed into credit balances; and
d. Identify any money recouped from such providers

Response:

EFADS is a fully integrated component of the MMIS. The reporting solution employs COGNOS ReportNet technology and supporting analytics run on an Oracle platform data mart loaded from the DSS data warehouse.

The system is comprised of two major components:

- Enterprise Fraud Analytics (EFA):
  - Uses customized analytical filters and statistical models, Enterprise Fraud Analytics provide complex and specific intra-claim and cross-claim analysis to detect fraud schemes.

- Enterprise Surveillance and Utilization Review (ESUR):
  - Uses peer-grouping methods to provide surveillance and utilization reviews of providers and recipients to detect patterns of behavior;
  - Meets CMS SUR certification requirements for State Medicaid programs; and
  - Replaces the traditional MMIS SUR subsystem

The EFADS reporting solution presents analytical and peer group profile results to the users, and supports drilldown into the detail claims data related to fraudulent activity.

In addition, DHCF has developed a Data Warehouse which provides additional data collection and mining capabilities. The additional capabilities include increased archived data, increased data limits and data fields, increased response time when running large reports, and a constantly evolving system to meet user needs.

With respect to EFADS and the Data Warehouse the following fraudulent or abusive utilization patterns have been identified:

- Personal Care Aide related claims with excessive units of service billed;
- Dental claims with excessive units of service billed;
- Durable Medical Equipment and Prosthetics, Orthotics and Medical Supplies billings without the required National Provider Identifier (NPI) for the referring provider;
- Providers billing for services reportedly provided to beneficiaries after the date of death;

- Physician services billed with the improper claims modifiers;
- Wound debridement claims with excessive units of service billed;
- Improper pharmacy claim activity;
- Mental health services claims with excessive units of service billed;

Through data mining, provider spike reports, provider summary reports, information sharing, and complaint review DHCF has initiated numerous preliminary investigations which determined a credible allegation of fraud exists based on a review of the provider's activities. These providers are listed in the table below.

Table 1: Providers that have been placed on review due to fraudulent activity

Provider Type or Recipient	Date Referred	Referred to	Penalty
Dental	9/2016	FBI	Payment Suspension
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	OAG	FCA Complaint, referral to DOH
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Recipient	2/2017	MFCU	Pending Criminal Investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation

Key: MFCU - Medicaid Fraud Control Unit; FCA – False Claim Act; OAG – Office of the Attorney General; FBI - Federal Bureau of Investigation; DOH - Department of Health Licensing Authority

After the completion of a preliminary investigation, the agency makes referrals to law enforcement, when applicable. Federal regulation 42 CFR 455.23 requires the State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part. Many of the preliminary investigations conducted by DHCF focused on Personal Care Aides who do not have Medicaid Provider Numbers and do not bill the Medicaid program directly. Accordingly, although there were findings of credible allegations of fraud in PCA investigations and the cases were referred to the Medicaid Fraud Control Unit, DHCF does not have the ability to place the PCAs on payment suspension.

DEPARTMENT OF HEALTH CARE FINANCE

Q21: Please identify each incident of Medicaid abuse or fraud investigated in FY16 and to date in FY17 and any associated sanction/penalty. What problem areas or patterns have been discovered regarding fraud in the District's Medicaid program? Please identify providers and amounts recouped for each, including any supporting documentation.

Response:

DHCF investigated, or continues to investigate, 30 cases of alleged Medicaid fraud in Fiscal Year 2016. In Fiscal Year 2016, 10 cases were referred to law enforcement. In Fiscal Year 2017 DHCF investigated, or continues to investigate, 19 cases of alleged Medicaid fraud, and 7 cases have been referred to law enforcement based on a credible allegation of fraud determination. Problem areas that have been identified include:

- Personal Care Aides billing for multiple patients across home health agencies for the same hours;
- Billing for services not rendered; and
- Providing services without maintaining the necessary supporting documentation to justify the billing;

DHCF's Division of Program Integrity (DPI) includes an Investigations Branch, a Surveillance Utilization Review Section (SURS), and a Data Analytics Branch. Although the Investigations Branch focuses on the investigation of fraud based on information or data mining obtained from various sources and SURS focuses on audits of providers to ensure proper billing utilization, the branches work in conjunction with each other. These joint efforts can include combined data mining efforts, joint efforts on specific cases (such as an audit based on statistical sampling to identify trends and a follow-up or concurrent investigation to determine if there is a related credible allegation of fraud), and referrals from one branch to the other when an audit identifies potential fraud or investigation determines the case involves abuse through a credible allegation of fraud.

In addition, DPI oversees program integrity activities conducted by the District's Managed Care Organizations (including audits and investigations) and conducts information sharing and coordination with the Department of Behavioral Health and Department on Disability Services concerning program integrity issues.

The preliminary investigations which have resulted in a credible allegation of fraud and a referral to law enforcement identified the problem areas or patterns above, however, the collective program integrity efforts resulted in the discovery of the following problem areas or patterns:

- Personal Care Aide related claims with excessive units of service billed.
- Dental claims with excessive units of service billed.

- Durable Medical Equipment and Prosthetics, Orthotics and Medical Supplies billings without the required National Provider Identifier (NPI) for the referring provider.
- Providers billing for services reportedly provided to beneficiaries after the date of death.
- Physician services billed with the improper claims modifiers.
- Wound debridement claims with excessive units of service billed.
- Improper pharmacy claim activity.
- Mental health services claims with excessive units of service billed.
- Supported Living Services claims with lack of documentation

The audits identifying abuse, including overpayment determinations and recovery amounts are provided in the response to Question 23.

DHCF does not recoup funds from providers suspected of committing fraud. After the completion of a preliminary investigation, the agency makes referrals to law enforcement, when applicable. Federal regulation 42 CFR 455.23 requires that the State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity, unless the agency has good cause to not suspend payments or to suspend payment only in part.

Please refer to the table below for more detail on the investigative cases.

Provider Type or Recipient	Date Referred	Referred to	Penalty
Home Health, Aide	9/2016	OAG	FCA Complaint Filed
Dental	9/2016	FBI	Payment Suspension
IDD Waiver/Music Therapy			Referred to SURS for recoupment
Home Health, Agency			Referred to SURS for audit
Physicians			Referred to SURS for audit
Dental			On-going investigation
Home Health, Agency			Referred to SURS for audit
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation

Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	9/2016	MFCU	Pending Criminal Investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Recipient	2/2017	MFCU	Pending Criminal Investigation
Recipient			On-going investigation
Home Health, Aide			On-going investigation
Home Health, Aide			On-going investigation
Home Health, Aide			On-going investigation
Recipient			On-going investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Dental			On-going investigation
Physician			On-going investigation
Home Health, Aide			On-going investigation
Home Health, Aide			On-going investigation
Recipient			On-going investigation
Home Health, Aide			On-going investigation
Ophthalmologist			On-going investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Physical Therapy			On-going investigation
Recipient			On-going investigation
Recipient			On-going investigation
Home Health, Aide	2/2017	MFCU	Pending Criminal Investigation
Transportation			On-going investigation
Physician			On-going investigation
Rehab MRRS			On-going investigation
Mental Health Services			On-going investigation

Mental Health Services			On-going investigation
Pharmacy			On-going investigation
Pharmacy			On-going investigation
Home Health, Aide			On-going investigation
Home Health, Aide			On-going investigation
Occupational Therapist			On-going investigation
Home Health, Aide			On-going investigation
Mental Health Services			On-going investigation

DEPARTMENT OF HEALTH CARE FINANCE

Q22: Please provide a complete update on any patterns of Medicaid fraud and abuse that have been identified by the agency, and the measures that have been taken, to date, to address each of them.

Response:

Medical Fraud and Abuse Patterns

1. **Personal Care Aide related claims with excessive units of service billed**.

   Measures Taken To Address the Pattern

   DHCF promulgated three transmittals specifically related to Personal Care Aides (PCAs) which focused on enhanced oversight, including required Home Health Agency (HHA) investigations of PCAs involved in abnormal billing, required HHA reporting to the Department of Health (DOH) and DHCF, and documentation guidelines to more accurately account for PCA services which provides for increased effectiveness of PCA services audits. Transmittal #16-13 clarified the responsibility of Medicaid enrolled HHAs to report the termination of employees and/or contractors who are personal care aides to the DOH, Board of Nursing and requested the names and NPIs of the PCAs be sent to the DHCF's Division of Program Integrity. Transmittal #16-20 reminded HHAs that as of August 1, 2015, DHCF implemented a new edit in MMIS to deny all claims delivered by any personal care aide delivering more than 16 hours of service in a single day. The transmittal required HHAs to initiate an investigation of any related denied or voided claims into the validity of the services provided by the aide to the beneficiary served by the HHA. The transmittal provided directions if the HHA determined the services were provided. The transmittal also provided directions if the services were not provided, including providing DHCF's DPI with the results of the investigation, to take disciplinary action against the aide, and to report the aide to the Board of Nursing. Transmittal #16-23 provided a PCA Time and Activity Sheet guide, which was the result of a joint effort between DHCF staff and members of the provider community, to help improve the quality of PCA documentation and more accurately account for direct care activities that are delivered on any given date of service. Multiple training sessions were held with HHAs to discuss the above transmittals and to answer any questions.

   DHCF conducts regular data analysis of PCA claims data, including identifying top billing PCAs and weekly claims edits review to identify PCAs billing more than 16 hours in a day. Based on the data mining results, reports from HHAs, and other available information, preliminary investigations are initiated against the most egregious providers. The investigations have identified credible allegations of fraud, including billing for overlapping hours and billing for times outside the country based on information from the Department of Homeland Security. All PCA investigations are coordinated with law

enforcement agencies, including the identification of PCAs employed by HHAs currently under criminal investigation by law enforcement agencies. In cases were PCA referrals are declined for criminal investigation, DHCF has sought alternative resolution of cases. This has included referral of PCA investigation to the Office of the Attorney General (OAG). Coordinated efforts with the OAG have resulted in first filing of a False Claims Act complaint against a PCA. In addition, DHCF will refer cases to the DOH, Board of Nursing after coordination with program integrity partners.

DHCF continues to employ previous edits, including home health agencies submitting incorrect NPI numbers for PCA aides by adding denial edits to the Medicaid Management Information System (MMIS) to deny claims if the NPI submitted for the aide was the NPI of an existing DC Medicaid provider. This edit will deny claims if the Home Health Agency submits their own NPI as the NPI for the aide. DHCF also implemented system edits to ensure that the ordering provider participates in the DC Medicaid program and is authorized to order services. Home Health Agencies previously submitted claims where the ordering provider was a chiropractor or the Home Health Agency.

2. Dental claims with excessive units of service billed.

Measures Taken To Address the Pattern

Data mining is conducted on a periodic basis to identify abnormal billing dental providers. Based on the behavior identified in data mining and any additional information, such as complaints concerning dental providers an audit or investigation was initiated.

3. **Durable Medical Equipment and Prosthetics, Orthotics and Medical Supplies (DMEPOS) billings without the required National Provider Identifier (NPI) for the referring provider**.

Measures Taken To Address the Pattern

A project was initiated by SURS to identify providers through data analysis who billed for DMEPOS services without the proper NPI for the referring provider. Audits were initiated on providers whose claims did not comply with the billing requirements.

4. Providers billing for services reportedly provided to beneficiaries after the date of death.

Measures Taken To Address the Pattern

Once a quarter, the MMIS contractor conducts a review to capture claims submitted after a beneficiary's date of death. The resulting claims data is provided to DHCF. DHCF's

DPI verifies the beneficiary date of death data against multiple databases and recoups any identified overpayment amounts.

5. **Physician services billed with the improper claims modifiers.**

   Measures Taken To Address the Pattern

   A project was initiated by SURS to identify providers through data analysis who billed with improper claims modifiers. Audits were initiated on providers whose claims indicated abnormal billing practices.

6. **Wound debridement claims with excessive units of service billed.**

   Measures Taken To Address the Pattern

   A project was initiated by SURS to identify providers through data analysis who billed for excessive units of service. Audits were initiated on providers whose claims indicated abnormal billing practices.

7. **Improper pharmacy billings, data analysis and audits identified various issues including wrong or incorrect day supply, prescriptions not received, quantity billed exceeds quantity authorized, and other issues.**

   Measures Taken To Address the Pattern

   The Pharmacy Benefits manager conducts data analysis of pharmacy claims data, specifically the use of algorithms to identify abnormal claims and conducts audits based on data mining results. The results of the audits are shared with DHCF and DPI completes offsets to the provider's payments to recoup identified overpayments. DPI conducts investigations based on complaints or other information indicating potential fraudulent activities.

8. **Mental health services claims with excessive units of service billed.**

   Measures Taken To Address the Pattern

   DBH conducts statistical sampling of mental health services claims and conducts audits to verify the services selected were provided in accordance with rules and policies. The results of the audits are shared with DHCF and DPI completes offsets to the provider's payments to recoup identified overpayments.

9. **Supported Living Services claims with lack of documentation**

   Measures Taken To Address the Pattern

A project was initiated by SURS to conduct statistical sampling of supported living services claims. Audits were initiated on providers based on the sampling results and other information.

DEPARTMENT OF HEALTH CARE FINANCE

Q23. Please describe each audit conducted by the Division of Program Integrity, Surveillance and Utilization Review in FY16 and FY17, to date, including the provider type, the amount of funds recovered, and the providers identified as high to moderate risk for potential utilization of service.

Response:

SURS Audit Tracking FY 2016

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2016	DHCF Identified Risk Level (Limited, Moderate or High)
1	IDD/Waiver	Supported Employment - Over Utilization	$502,881.40	Exceeded Benefit Maximum for supported employment Intake and Assessment and Job Placement and Training Services.	$502,881.40	$102,298.68	$17,571.76	Moderate Risk
2	Transportation	MFCU	$44,551.50	Transportation services on days without a medical appointment	$44,551.50	N/A	$2,053.75	Limited Risk
3	IDD/Waiver	Supported Employment - Over Utilization - U1, U2, U3 and U4	$246,933.12	Exceeded Benefit Maximum for supported employment Intake, Assessment, Job Placement, and Training Services.	$246,933.12	$35,466.99	$21,137.11	Moderate Risk
4	Home Health - PCA State Plan	Home Health PCA Services	$1,316,476.09	Lack of documentation to support billing and reimbursement, including activity/flow sheets. • Lack of description and dates of services rendered, including the name and NPI of the personal care aide performing the services. • Missing medical records.	$1,285,237.68	$1,285,237.68	$240,984.36	High Risk
5	IDD/Waiver	Supported Employment - Over Utilization	$554,028.15	Exceeded Benefit Maximum for supported employment Intake and Assessment and Job Placement and Training Services.	$55,402.15	N/A	$0.00	Moderate Risk
6	Mental Health	Mental Health - DBH Failed Claims	$120.60	DBH Failed Claims	$120.60	N/A	$0.00	Moderate Risk
7	DBH	Failed Claims	$7,443.16	Lack of documentation .Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$7,443.16	N/A	$7,443.16	Moderate Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2016	DHCF Identified Risk Level (Limited, Moderate or High)
8	DBH	Mental Health - DBH Failed Claims	$1,353.55	Lack of documentation .Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,353.55	N/A	$338.40	Moderate Risk
9	DBH	Mental Health - DBH Failed Claims	$304.04	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$304.04		$304.04	Moderate Risk
10	DBH	Mental Health - DBH Failed Claims	$2,002.72	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$2,002.72	N/A	$1,502.02	Moderate Risk
11	Mental Health	Mental Health - DBH Failed Claims	$1,040.40	DBH Failed Claims	$1,040.40	N/A	$1,040.40	Moderate Risk
12	Hospital - MIP	DRG - Review of Same Day Patients	$914,498.42	DRG - Review of Same Day Patients	$715,000.00	$715,000.00	$714,999.96	Limited Risk
13	Physician	PERM	$0.00	No response to request.	$0.00	N/A	$0.00	Limited Risk
14	Hospital	MIP - Inpatient	$1,030,214.32	Medical Necessary , Lack of Documentation to support claim	$773,201.18	$541,240.83	$541,240.83	Limited Risk
15	Home Health - PCA (HMS/CMS/ DHCF Audit)	PCA/Home Health Audits conducted by HMS for DHCF/CMS	$659,498.00	Unauthorized Service, Service not Provided, and Non Covered Service	$67,321.00	$36,652.00	$36,652.00	High Risk
16	Home Health - PCA (HMS/CMS/ DHCF Audit)	PCA/Home Health Audits conducted by HMS for DHCF/CMS	$1,930,912.00	Unauthorized Service, Service not Provided, and Non Covered Service	$157,903.64	$104,796.85	$104,796.85	High Risk
17	DBH	Mental Health - DBH Failed Claims	$13,748.26	Lack of documentation .Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$13,748.26	N/A	$13,748.26	Moderate Risk
18	DBH	Mental Health - DBH Failed Claims	$13,748.26	Lack of documentation .Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$3,497.78	N/A	$3,797.78	Moderate Risk
19	DBH	Mental Health - DBH Failed Claims	$22,243.36	Lack of documentation .Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$22,243.36	N/A	$22,243.36	Moderate Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2016	DHCF Identified Risk Level (Limited, Moderate or High)
20	DBH	Failed Claims	$1,669.53	Lack of documentation .Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,669.53	N/A	$1,669.53	Moderate Risk
21	DBH	Failed Claims	$48,341.10	Lack of documentation .Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$48,341.10	N/A	$48,341.10	Moderate Risk
22	DBH	Mental Health - DBH Failed Claims	$10,386.35	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$10,386.35	N/A	$10,386.35	Moderate Risk
23	DBH	Mental Health - DBH Failed Claims	$1,748.47	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,748.47	N/A	$1,748.40	Moderate Risk
24	DBH	Mental Health - DBH Failed Claims	$4,035.06	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$12,105.18	N/A	$12,105.17	Moderate Risk
25	DBH	Mental Health - DBH Failed Claims	$16,915.96	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$16,915.96	N/A	$16,915.95	Moderate Risk
26	IDD/Waiver	Supported Living billed U5 & U6 on the same date, and billed U6 & U5 on the same date.	$200,366.00	Provider approved for U5 only but billed and reimbursed for U6 and U5 on the same DOS. Approved for U6 only but billed and reimbursed for U5 and U6 on the same DOS.	$189,660.00	N/A	$189,660.00	Moderate Risk
27	DBH	Mental Health - DBH Failed Claims	$562.23	DBH Failed Claims	$562.23	N/A	$562.23	Moderate Risk
28	DBH	Mental Health - DBH Failed Claims	$9,649.24	DBH Failed Claims	$9,649.24	N/A	$9,649.24	Moderate Risk
29	DBH	Mental Health - DBH Failed Claims	$10,354.65	DBH Failed Claims	$10,354.65	N/A	$10,354.65	Moderate Risk
30	DBH	Mental Health - DBH Failed Claims	$326.23	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$326.23	N/A	$326.23	Moderate Risk
31	DBH	Mental Health - DBH Failed Claims	$1,661.44	Lack of documentation, Invalid treatment plan.	$1,353.55	N/A	$1,353.55	Moderate Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2016	DHCF Identified Risk Level (Limited, Moderate or High)
32	DBH	Mental Health - DBH Failed Claims	$282.15	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$282.15	N/A	$282.15	Moderate Risk
33	DBH	Mental Health - DBH Failed Claims	$2,721.64	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$2,721.64	N/A	$2,721.64	Moderate Risk
34	DBH	Mental Health - DBH Failed Claims	$634.45	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$634.45	N/A	$634.45	Moderate Risk
35	DBH	Mental Health - DBH Failed Claims	$17,329.92	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$17,329.92	N/A	$17,329.92	Moderate Risk
36	DBH	Mental Health - DBH Failed Claims	$1,428.41	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,428.41	N/A	$1,428.41	Moderate Risk
37	DBH	Mental Health - DBH Failed Claims	$13,897.98	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$13,897.98	N/A	$13,897.98	Moderate Risk
38	DBH	Mental Health - DBH Failed Claims	$3,359.00	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$3,359.00	N/A	$3,359.00	Moderate Risk
39	DBH	Mental Health - DBH Failed Claims	$15,062.59	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$15,062.59	N/A	$15,062.59	Moderate Risk
40	DBH	Mental Health - DBH Failed Claims	$697.62	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$697.62	N/A	$697.62	Moderate Risk
41	DBH	Mental Health - DBH Failed Claims	$1,576.92	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,576.92	N/A	$1,576.92	Moderate Risk
42	DBH	Mental Health - DBH Failed Claims	$840.15	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$840.15	N/A	$840.15	Moderate Risk
43	DBH	Mental Health - DBH Failed Claims	$1,240.78	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,240.78	N/A	$2,481.53	Moderate Risk
44	DBH	Mental Health - DBH Failed Claims	$11,011.48	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$11,011.48	N/A	$11,011.48	Moderate Risk

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45	DBH	Mental Health - DBH Failed Claims	$974.68	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$974.68	N/A	$974.68	Moderate Risk
46	Physician	Dermatology	$89.60	Lack of Documentation to support billing for E/M codes	$89.60	N/A	$89.60	Limited Risk
47	DBH	Failed Claims	$2,330.77	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$2,330.77	N/A	$2,330.77	Moderate Risk
48	DBH	Failed Claims	$289.54	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$289.54	N/A	$289.54	Moderate Risk
49	DBH	Mental Health - DBH Failed Claims	$2,566.80	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$2,566.80	N/A	$2,566.80	Moderate Risk
50	DBH	Mental Health - DBH Failed Claims	$1,285.73	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,285.73	N/A	$1,285.73	Moderate Risk
51	DBH	Mental Health - DBH Failed Claims	$5,692.73	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$5,692.73	N/A	$5,218.40	Moderate Risk
52	DBH	Mental Health - DBH Failed Claims	$7,638.12	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$7,638.12	N/A	$7,638.12	Moderate Risk
53	DBH	Mental Health - DBH Failed Claims	$2,441.53	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$2,441.53	N/A	$2,441.53	Moderate Risk
54	DBH	Mental Health - DBH Failed Claims	$7,643.73	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$7,643.73	N/A	$7,643.73	Moderate Risk
55	DBH	Mental Health - DBH Failed Claims	$2,352.30	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$2,352.30	N/A	$2,352.30	Moderate Risk
56	DBH	Mental Health - DBH Failed Claims	$5,406.43	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$5,406.43	N/A	$5,406.43	Moderate Risk
57	DBH	Mental Health - DBH Failed Claims	$774.81	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$774.81	N/A	$774.81	Moderate Risk

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58	DBH	Mental Health - DBH Failed Claims	$17,094.94	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$17,094.94	N/A	$17,094.93	Moderate Risk
59	DBH	Mental Health - DBH Failed Claims	$20,515.91	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$20,515.91	N/A	$20,515.91	Moderate Risk
60	DBH	Mental Health - DBH Failed Claims	$8,268.48	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$8,268.48	N/A	$8,268.48	Moderate Risk
61	DBH	Mental Health - DBH Failed Claims	$8,840.30	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$8,840.30	N/A	$8,840.30	Moderate Risk
62	DBH	Mental Health - DBH Failed Claims	$6,477.49	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$6,477.48	N/A	$6,477.48	Moderate Risk
63	DBH	Mental Health - DBH Failed Claims	$1,661.44	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,661.44	N/A	$1,661.44	Moderate Risk
64	DBH	Mental Health - DBH Failed Claims	$114.48	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$114.48	N/A	$0.00	Moderate Risk
65	Home Health - PCA State Plan	PCA services - NPI Review	$755.20	NPI # for the PCA delivering services not included on the claims submitted to Medicaid for Reimbursement	$755.20	N/A	$775.20	High Risk
66	Home Health - PCA State Plan	PCA services - NPI Review	$107,516.92	NPI # for the PCA delivering services not included on the claims submitted to Medicaid for Reimbursement	$107,516.92	N/A	$107,233.64	High Risk
67	Home Health - PCA State Plan	PCA services - NPI Review	$23,250.32	NPI # for the PCA delivering services not included on the claims submitted to Medicaid for Reimbursement	$23,250.32	N/A	$23,250.32	High Risk
68	DBH	Mental Health - DBH Failed Claims	$263.64	Lack of documentation.	$263.64	N/A	$263.64	Moderate Risk
69	Home Health - PCA (HMS/CMS/ DHCF Audit)	PCA/Home Health Audits conducted by HMS for DHCF/CMS	$1,703,672.00	Unauthorized Service, Service not Provided, and Non Covered Service	$85,739.32	$68,591.00	$68,591.00	High Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2016	DHCF Identified Risk Level (Limited, Moderate or High)
70	DBH	Mental Health - DBH Failed Claims	$153.00	Lack of documentation	$153.00	N/A	$153.00	Moderate Risk
71	DME - Date of death review	Billing after DOD	$280.84	Billed for services after the date of death.	$280.84	N/A	$280.84	High Risk
72	DBH	Mental Health - DBH Failed Claims	$11,072.26	Encounter note does not substantiate the claim	$11,072.26	N/A	$11,072.25	Moderate Risk
73	DBH	Mental Health - DBH Failed Claims	$20,359.46	Encounter note does not substantiate the claim	$20,359.46	$12,500.00	$12,500.00	Moderate Risk
74	DBH	Mental Health - DBH Failed Claims	$5,297.55	Invalid plan. Service not billable.No submission.	$5,297.55	N/A	$5,297.55	Moderate Risk
75	DBH	Mental Health - DBH Failed Claims	$17,978.20	Duration and actual time not documented. Improper coding.	$17,978.20	N/A	$17,978.20	Moderate Risk
76	IDD/Waiver	PERM	$380.00	Lack of documentation	$380.00	N/A	$380.00	Moderate Risk
77	DBH	Mental Health - DBH Failed Claims	$10,181.49	Lack of documentation	$10,181.97	N/A	$10,181.97	Moderate Risk
78	DBH	Mental Health - DBH Failed Claims	$835.76	Lack of documentation	$835.76	N/A	$835.76	Moderate Risk
79	DBH	Mental Health - DBH Failed Claims	$367.66	Lack of documentation	$367.66	N/A	$373.66	Moderate Risk
80	Physician	PERM	$231.60	Non-Response to request for records service 93880-Arterial Scan	$231.60	N/A	$231.60	Limited Risk
81	Mental Health Rehab Services	PERM	$190.20	Receipt of Insufficient Information H0039- Assertive Community Training/15 Min	$190.20	N/A	$190.20	Moderate Risk
82	IDD/Waiver	PERM	$349.44	Receipt of Insufficient Information T2017-HABILITATION, RESIDENTIAL, WAIVER; 15 MINUTES	$349.44	N/A	$349.44	Moderate Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2016	DHCF Identified Risk Level (Limited, Moderate or High)
83	Physician	PERM	$347.25	Insufficient documentation to support billed services	$347.25	$347.25	$0.00	Limited Risk
84	RehabMHRS	PERM	$241.67	Receipt of Insufficient information	$241.67	N/A	$241.67	Moderate Risk
85	Hosp Gen	PERM	$28.81	Receipt of Insufficient information	$28.81	N/A	$28.81	Limited Risk
86	EPD	PERM	$130.56	Non-Response for additional information	$130.56	N/A	$130.56	Moderate Risk
87	ICF/MR	PERM	$4,184.46	Non-Response for additional information	$4,184.46	N/A	$4,184.46	Moderate Risk
88	Mental Health Clinic	PERM	$395.47	Insufficient documentation, no response for request.	$395.47	N/A	$395.47	Moderate Risk
89	Physician	PERM	$65.72	No response to request.	$65.72	N/A	$64.13	Limited Risk
90	Hospice	Eligibility Reviews for Hospice Services	N/A	Medical records did not document and/or support recipient eligibility for Hospice Benefit	$144,370.58	N/A	$144,370.58	Moderate Risk
91	DME - Date of death review	Billing after DOD	$281.88	Billed for services after the date of death.	$281.88	N/A	$281.88	High Risk
92	Behavioral Health	PERM	$173.29	Number of units billed exceeds number of units authorized	$173.29	N/A	$173.29	Moderate Risk
93	Home Health	PCA services - NPI Review	$11,025.92	Services billed using the organizational NPI number and not the NPI number of the PCA delivering the services as required in regulation	$11,025.92	N/A	$11,025.92	High Risk
94	Home Health	PCA services - NPI Review	$151.04	Services billed using the organizational NPI number and not the NPI number of the PCA delivering the services as required in regulation	$151.04	N/A	$151.04	High Risk
95	Home Health	PCA services - NPI Review	$187,133.24	Services billed using the organizational NPI number and not the NPI number of the PCA delivering the services as required in regulation	$187,133.24	N/A	$187,133.24	High Risk
96	Home Health	PCA services - NPI Review	$2,737.60	Services billed using the organizational NPI number and not the NPI number of the PCA delivering the services as required in regulation	$2,737.60	N/A	$2,737.60	High Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2016	DHCF Identified Risk Level (Limited, Moderate or High)
97	DME - Date of death review	Billing after DOD	$157.20	Billed for services after the date of death.	$157.20	N/A	$157.20	High Risk
98	Pharmacy - Date of Death Review	Billing after DOD	$129.28	Billed for services after the date of death.			$129.28	Moderate Risk
99	Mental Health	Mental Health - DBH Failed Claims	N/A	DBH Failed Claims	$1,866.93	N/A	$780.00	Moderate Risk
100	IDD/Waiver	Supported Employment - Over Utilization	$1,435,442.05	Exceeded Benefit Maximum for supported employment Intake and Assessment and Job Placement and Training Services.	$1,435,442.05	N/A	$259,370.75	Moderate Risk
101	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$128,261.61	Billed for quantity greater than dispensed	$123,469.81	$123,469.81	$20,627.12	Moderate Risk
102	IDD/Waiver	Host Home billed with PCA services	$8,812.80	Billed PCA sevices while recipient was receiving Home Services	$8,812.80	N/A	$8,812.80	Moderate Risk
103	Home Health - PCA (HMS/CMS/ DHCF Audit)	PCA/Home Health Audits conducted by HMS for DHCF/CMS	$1,280,072.00	Unauthorized Service, Service not Provided, and Non Covered Service	$153,518.24	N/A	$0.00	High Risk
104	Home Health - PCA (HMS/CMS/ DHCF Audit)	PCA/Home Health Audits conducted by HMS for DHCF/CMS	$1,110,052.00	Unauthorized Service, Service not Provided, and Non Covered Service	$130,087.24	N/A	$0.00	High Risk
105	DBH	Mental Health - DBH Failed Claims	$3,912.44	No encounter note found for DOS. Altered treatment plan. No audit response document submitted. No records found for consumer. Invalid treatment plan	$3,912.44	N/A	$3,260.29	Moderate Risk
106	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$23,671.87	Claims submitted with ID number that was not the ID number of the physician who authorized the prescription. Quantity Billed exceeds the quantity authorized by the prescriber/plan. Prescription refilled sooner than appropriate with respect to quantity and directions for use.	$22,555.13	$14,000.00	$9,478.94	Moderate Risk
107	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$10,255.87	Rx not found on file. Submitted days' supply on claim is incorrect.	$9,569.57	N/A	$0.00	Moderate Risk

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108	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$8,763.87	The hardcopy prescription does not indicate directions for use or dosage. Incomplete Directions. Drug, quantity or refills altered with no documentation on Rx. Submitted days' supply on claim is incorrect.	$8,521.10	N/A	$0.00	Moderate Risk
109	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$23,793.60	Pharmacy billed for a different medication than the one ordered by the Prescriber with no documentation on Rx or Patient Profile (Must have Pharmacist notes on Rx; Brand was billed/Generic dispensed).	$23,793.60	N/A	$0.00	Moderate Risk
110	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$2,714.84	The hardcopy prescription does not indicate directions for use or dosage. Incomplete Directions. Excess quantity dispensed. Prescription is refilled sooner than appropriate with respect to quantity and directions for use.	$2,358.59	N/A	$0.00	Moderate Risk
111	DBH	Mental Health - DBH Failed Claims	$1,442.79	DBH Failed Claims	$1,442.79	N/A	$1,442.79	Moderate Risk
112	DBH	Mental Health - DBH Failed Claims	$981.12	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$981.12	N/A	$654.08	Moderate Risk
113	DBH	Mental Health - DBH Failed Claims	$1,472.53	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,472.53	N/A	$0.00	Moderate Risk
114	IDD/Waiver	Supported Employment/ Day Habilitation	$3,498.49	Supported Employment and Day Habilitation services Billed concurrently	$3,498.49	N/A	$0.00	Moderate Risk
115	IDD/Waiver	Residential Habilitation Services	$23,920.00	Provider bellied and paid for more than one residential habilitation service for the same date of service.	$23,920.00	N/A	$0.00	Moderate Risk
116	DBH	Mental Health - DBH Failed Claims	$15,413.58	No Submission. Encounter note does not substantiate the claim	$15,413.58	N/A	$5,308.50	Moderate Risk
117	DBH	Mental Health - DBH Failed Claims	$5,909.13	Encounter note does not substantiate the claim	$5,909.13	N/A	$1,519.02	Moderate Risk
118	Physician	PERM	$735.85	Lack of documentation	$735.85	N/A	$0.00	Limited Risk
119	Physician	PERM	$1,050.00	Lack of documentation	$1,050.00	N/A	$0.00	Limited Risk

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120	Nursing Home	PERM	$6,392.62	Lack of documentation	$6,392.62	N/A	$4,794.48	Limited Risk
121	Public Charter School	PERM	$328.80	Lack of documentation	$328.80	N/A	$39.29	Limited Risk
122	IDD/Waiver	PERM	$1,653.60	Lack of documentation	$1,653.60	N/A	$1,378.00	Moderate Risk
123	Home Health - PCA State Plan	PERM	$525.07	Lack of documentation	$525.07	N/A	$525.07	High Risk
124	Physician	PERM	$412.78	Lack of documentation	$412.78	N/A	$412.78	Limited Risk
125	Physician	PERM	$745.88	Lack of documentation	$745.88	N/A	$0.00	Limited Risk
126	IDD/Waiver	Waiver services	$58,747.50	Lack of documentation, billing on holidays, Sundays and when business closed. Billing more than one recipient on same day and same hours.	$58,747.50	N/A	$0.00	Moderate Risk
127	RehabMHRS	PERM	$19.19	Number of units billed exceeds number of units authorized. Administrative write off per Donald Shearer.	$19.19	N/A	$0.00	Moderate Risk
128	RehabMHRS	PERM	$19.19	Number of units billed exceeds number of units authorized. Administrative write off per Donald Shearer.	$19.19	N/A	$0.00	Moderate Risk
129	Pharmacy Retail	PERM	N/A	Insufficient documentation, no response for request.	N/A	N/A	$0.00	Moderate Risk
130	Mental Health Rehab Services	PERM	$134.33	Non-Response to request for records service H0036-COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT, FACE-TO-FACE, PER 15 MINUTES	$134.33	N/A	$0.00	Moderate Risk
131	Independent Lab	PERM	N/A	Non-Response to Request for Record for 36415-Venipuncture	N/A	N/A	$0.00	Limited Risk
132	Nursing Home	review of paid services	$0.00	No Error Identified for the identified audit period	$0.00	N/A	$0.00	Limited Risk
133	Hospice	Eligibility Reviews for Hospice Services	N/A	Medical records did not document and/or support recipient eligibility for Hospice Benefit	$97,446.30	N/A	$0.00	Moderate Risk
134	Pharm - Date of death review	Billing after DOD	$347.67	Billed for services after the date of death.			$0.00	Moderate Risk

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135	School-based Services	PERM	$1,373.69	Lack of documentation. Invalid treatment plan. Provider signature not dated. No response to requests for additional documentation.	$1,373.69	N/A	$572.20	Limited Risk
136	Pharmacy - Date of Death Review	Billing after DOD	$118.65	Billed for services after the date of death.		N/A	$0.00	Moderate Risk
137	DME - Date of death review	Billing after DOD	$849.00	Billed for services after the date of death.		N/A	$0.00	High Risk
138	RehabMHRS	Billing after DOD	$114.12	Billed for services after the date of death.		N/A	$0.00	Moderate Risk
139	Pharm - Date of death review	Billing after DOD	$1,001.58	Billed for services after the date of death.		N/A	$0.00	Moderate Risk
140	Home Health -PCA (HMS/CMS/ DHCF Audit)	PERM	$65.00	Insufficient documentation, no response for request.	$65.00	65.00	$0.00	High Risk
141	Home Health - PCA (HMS/CMS/ DHCF Audit)	PERM	$1,741.19	Insufficient documentation, no response for request.	$1,741.19	1741.19	$1,015.70	High Risk
142	DME -No referring Physician	Billed for services under their provider ID#	$62708.56	Billed for services with no referring physician			$0.00	High Risk
143	DENTAL	Documentation of services	$59,111.70	undocumented services, unsigned documentation or documented under a different name, incorrect procedure code, services provided on a different date of service			$0.00	Limited Risk
144	PHYSICIAN	Unbundling	$19,345.43	Service billed inappropriately with 59 modifier			$0.00	Limited Risk
145	PHYSICIAN	Unbundling	$8,918.70	Service billed inappropriately with 59 modifier			$0.00	Limited Risk
146	DME	Billed for services under their provider ID#	$11,143.28	Billed for services with no referring physician			$0.00	High Risk
147	DME	Billed for services under their provider ID#	$2,955.01	Billed for services with no referring physician			$0.00	High Risk
148	DME	Billed for services under their provider ID#	$329.50	Billed for services with no referring physician			$0.00	High Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2016	DHCF Identified Risk Level (Limited, Moderate or High)
149	DME	Billed for services under their provider ID#	$6,786.00	Billed for services with no referring physician			$0.00	High Risk
150	IDD/Waiver	Billing for two codes concurrently	$0.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00		$0.00	Moderate Risk
151	IDD/Waiver	Billing for two codes concurrently	$0.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00		$0.00	Moderate Risk
152	IDD/Waiver	Supported Living Services T2016 HI, U1 and T2016 HI, U8 were incorrectly billed concurrently.	$276.37	Supp living (3) Basic Support Level1 W/Trans cannot be billed with Supp Living (2) Basic Support Level 2 W/Trans. concurrently	$276.37		$0.00	Moderate Risk
153	IDD/Waiver	Billing for two codes concurrently	$5,796.28	Supp Living (2) Mod Suppt Lev 2-I/DD can not be billed concurrently with Supp Living (2) Basic Suppt Lev 2-I/DD	$5,796.28		$0.00	Moderate Risk
154	IDD/Waiver	Billing for two codes concurrently	$23,662.00	Supp Liv (2) Basic Support Level 2 W/Trans. And Supp Liv (2) Basic Support Level 2-I/DD can not be billed concurrently.	$23,662.00		$0.00	Moderate Risk
155	IDD/Waiver	Billing for two codes concurrently	$0.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00		$0.00	Moderate Risk
156	IDD/Waiver	Billing for two codes concurrently	$0.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00		$0.00	Moderate Risk
157	IDD/Waiver	Billing for two codes concurrently	$0.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00		$0.00	Moderate Risk
158	IDD/Waiver	Billing for two codes concurrently	$0.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00		$0.00	Moderate Risk
159	DBH	Mental Health - DBH Failed Claims	$4,779.23	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.			$0.00	Moderate Risk
160	Physician	Wound debridement	$4,168.08	Missing or incomplete physician documentation.	$4,168.08		$0.00	Limited Risk
161	Physician	Wound debridement	$143.29	Missing or incomplete physician documentation.	$143.29		$0.00	Limited Risk

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162	IDD/Waiver	Behavioral Support Services	$1,702.80	Lack of documentation.	$1,702.80		$0.00	Moderate Risk
163	IDD/Waiver	Behavioral Support Services	$4,747.20	Lack of documentation.	$4,747.20		$0.00	Moderate Risk
164	Goo-ICF/MR	PERM	$8,368.68	Failure to submit documentation to support the claim that was paid in accordance with State policy.	$8,368.68	N/A	$6,304.32	Moderate Risk

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1	IDD/Waiver	Supported Employment - Over Utilization	$ 1,435,442.05	Exceeded Benefit Maximum for supported employment Intake, Assessment, Job Placement, and Training Services.	$1,435,442.05	N/A	$336,663.77	Moderate Risk
2	DME	DME	$95.97	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.	$95.97		$0.00	High Risk
3	Home Health - PCA (HMS/CMS/ DHCF Audit)	PCA/Home Health Audits conducted by HMS for DHCF/CMS	$ 1,110,052.00	Unauthorized Service, Service not Provided, and Non Covered Service	$130,087.24	N/A	$72,500.00	High Risk
4	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$23,671.87	Claims submitted with ID number that was not the ID number of the physician who authorized the prescription. Quantity Billed exceeds the quantity authorized by the prescriber/plan. Prescription refilled sooner than appropriate with respect to quantity and directions for use.	$22,555.13	$14,000.00	$11,520.57	Moderate Risk
5	DME	DME	$196,540.17	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.			$0.00	High Risk

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6	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$128,261.61	Billed for quantity greater than dispensed	$123,469.81	$123,469.81	$20,627.12	Moderate Risk
7	Home Health - PCA (HMS/CMS/ DHCF Audit)	PCA/Home Health Audits conducted by HMS for DHCF/CMS	$ 1,280,072.00	Unauthorized Service, Service not Provided, and Non Covered Service	$153,518.24	N/A	$0.00	High Risk
8	IDD/Waiver	Supported Employment/ Day Habilitation	$3,498.49	Supported Employment and Day Habilitation services Billed concurrently	$3,498.49	N/A	$3,498.49	Moderate Risk
9	IDD/Waiver	Residential Habilitation Services	$23,920.00	Provider billed and paid for more than one residential habilitation service for the same date of service.	$23,920.00	N/A	$23,919.96	Moderate Risk
10	DBH	Mental Health - DBH Failed Claims	$ 3,912.44	No encounter note found for DOS. Altered treatment plan. No audit response document submitted. No records found for consumer. Invalid treatment plan	$3,912.44	N/A	$3,260.29	Moderate Risk
11	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$10,255.87	Rx not found on file. Submitted days' supply on claim is incorrect.	$9,569.57	N/A	$0.00	Moderate Risk
12	Pharmacy Audit DHCF/Xerox	Contracted Audit with Xerox	$2,714.84	The hardcopy prescription does not indicate directions for use or dosage. Incomplete Directions. Excess quantity dispensed. Prescription is refilled sooner than appropriate with respect to quantity and directions for use.	$2,358.59	N/A	$0.00	Moderate Risk
13	DBH	Mental Health - DBH Failed Claims	$981.12	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$981.12	N/A	$654.08	Moderate Risk
14	DBH	Mental Health - DBH Failed Claims	$1,472.53	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,472.53	N/A	$0.00	Moderate Risk
15	DBH	Mental Health - DBH Failed Claims	$15,413.58	No Submission. Encounter note does not substantiate the claim	$15,413.58	N/A	$5,308.50	Moderate Risk
16	DBH	Mental Health - DBH Failed Claims	$5,909.13	Encounter note does not substantiate the claim	$5,909.13	N/A	$1,519.02	Moderate Risk

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17	Physician	PERM	$735.85	Lack of documentation	$735.85	N/A	$0.00	Limited Risk
18	Physician	PERM	$1,050.00	Lack of documentation	$1,050.00	N/A	$0.00	Limited Risk
19	Nursing Home	PERM	$6,392.62	Lack of documentation	$6,392.62	N/A	$4,794.48	Limited Risk
20	Public Charter School	PERM	$328.80	Lack of documentation	$328.80	N/A	$39.29	Limited Risk
21	IDD/Waiver	PERM	$1,653.60	Lack of documentation	$1,653.60	N/A	$1,378.00	Moderate Risk
22	Hospice	Eligibility Reviews for Hospice Services	N/A	Medical records did not document and/or support recipient eligibility for Hospice Benefit	$97,446.30	N/A	$0.00	Moderate Risk
23	Physician	PERM	$745.88	Lack of documentation	$745.88	N/A	$0.00	Limited Risk
24	IDD/Waiver	Waiver services	$58,747.50	Lack of documentation, billing on holidays, Sundays and when business closed. Billing more than one recipient on same day and same hours.	$58,747.50	N/A	$0.00	Moderate Risk
25	Mental Health Rehab Services	PERM	$134.33	Non-Response to request for records service H0036-COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT, FACE-TO-FACE, PER 15 MINUTES	$134.33	N/A	$0.00	Moderate Risk
26	Pharm - Date of death review	Billing after DOD	$347.67	Billed for services after the date of death.		N/A	$0.00	Moderate Risk
27	Home Health - PCA State Plan	PERM	$65.00	Insufficient documentation, no response for request.	$65.00	N/A	$65.00	High Risk
28	Home Health - PCA	PERM	$1,741.19	Insufficient documentation, no response for request.	$1,741.19	N/A	$1,741.19	High Risk
29	School-based Services	PERM	$1,373.69	Lack of documentation. Invalid treatment plan. Provider signature not dated. No response to requests for additional documentation.	$1,373.69	N/A	$572.20	Limited Risk
30	Pharmacy - Date of Death Review	Billing after DOD	$118.65	Billed for services after the date of death.			$0.00	Moderate Risk

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31	PHYSICIAN	Unbundling	$19,345.43	Service billed inappropriately with 59 modifier	$19,345.43	N/A	$14,657.58	Limited Risk
32	DME - Date of death review	Billing after DOD	$849.00	Billed for services after the date of death.			$0.00	High Risk
33	RehabMHRS	Billing after DOD	$114.12	Billed for services after the date of death.			$0.00	Limited Risk
34	Pharm - Date of death review	Billing after DOD	$1,001.58	Billed for services after the date of death.			$0.00	Moderate Risk
35	DME -No referring Physician	Billed for services under their provider ID#	$62,708.56	Billed for services with no referring physician	$8,952.47	N/A	$0.00	High Risk
36	DENTAL	Documentation of services	$59,111.70	undocumented services, unsigned documentation or documented under a different name, incorrect procedure code, services provided on a different date of service			$0.00	Limited Risk
37	PHYSICIAN	Unbundling	$8,918.70	Service billed inappropriately with 59 modifier	$8,918.70	N/A	$0.00	Limited Risk
38	DME	Billed for services under their provider ID#	$11,143.28	Billed for services with no referring physician	$0.00		$0.00	High Risk
39	DME	Billed for services under their provider ID#	$2,955.01	Billed for services with no referring physician	$2,955.01	488.82	$0.00	High Risk
40	DME	Billed for services under their provider ID#	$329.50	Billed for services with no referring physician	$329.50	N/A	$0.00	High Risk
41	DME	Billed for services under their provider ID#	$6,786.00	Billed for services with no referring physician	$6,786.00	N/A	$0.00	High Risk
42	IDD/Waiver	Supported Living Services T2016 U7	$4,152.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00		$0.00	Moderate Risk

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43	IDD/Waiver	Supported Living Services T2016 HI UC, HI UB, HI U2, U8	$21,726.38	All deficiencies have been noted and no overpayments are pending from this audit	$0.00		$0.00	Moderate Risk
44	IDD/Waiver	Supported Living Services T2016 UA, U8	$5,796.28	Supp Living (2) Mod Suppt Lev 2-I/DD can not be billed concurrently with Supp Living (2) Basic Suppt Lev 2-I/DD	$5,796.28		$0.00	Moderate Risk
45	DBH	Mental Health - DBH Failed Claims	4779.23	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.			$3,186.16	Moderate Risk
46	Physician	Wound debridement	493.19	Missing or incomplete physician documentation.	$4,168.08	N/A	$453.19	Limited Risk
47	IDD/Waiver	Behavioral Support Services	$1,702.80	Lack of documentation to support services billed	$1,702.80	N/A	$1,702.80	Moderate Risk
48	IDD/Waiver	Behavioral Support Services	$4,747.20	Lack of documentation to support services billed	$4,747.20	N/A	$3,164.80	Moderate Risk
49	IDD/Waiver	IDD Waiver Supported Living Periodic T2017 HI U1	$56,763.54	Lack of documentation to support services billed	$56,763.54	N/A	$56,763.54	Moderate Risk
50	IDD/Waiver	Supported Living Services T2016 UB HI, UB	$14,000.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00	N/A	$0.00	Moderate Risk
51	IDD/Waiver	Supported Living Services T2016 HI U8, U8 & HI U5, U5	$3,390.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00	N/A	$0.00	Moderate Risk
52	IDD/Waiver	Supported Livimng Services T2016 UB, U8	$8,090.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00	N/A	$0.00	Moderate Risk
53	IDD/Waiver	Supported Living Services T2016 U2,U6	$3,930.00	All deficiencies have been noted and no overpayments are pending from this audit	$0.00	N/A	$0.00	Moderate Risk
54	Physician	Wound debridement	$143.29	Missing or incomplete physician documentation.	$143.29	N/A	$0.00	Limited Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2017	DHCF Identified Risk Level (Limited, Moderate or High)
55	DBH	Mental Health - DBH Failed Claims	$9,108.99	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$9,108.99	N/A	$0.00	Moderate Risk
56	DBH	Mental Health - DBH Failed Claims	$1,829.20	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,829.20	N/A	$0.00	Moderate Risk
57	DBH	Mental Health - DBH Failed Claims	$466.65	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$466.65	N/A	$0.00	Moderate Risk
58	DBH	Mental Health - DBH Failed Claims	$1,673.44	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,673.44	N/A	$0.00	Moderate Risk
59	DBH	Mental Health - DBH Failed Claims	$19,509.52	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$19,509.52	N/A	$0.00	Moderate Risk
60	DBH	Mental Health - DBH Failed Claims	$1,442.34	Lack of documentation to support services billed	$1,442.34	N/A	$0.00	Moderate Risk
61	DBH	Mental Health - DBH Failed Claims	$100.48	Lack of documentation to support services billed	$100.48	N/A	$0.00	Moderate Risk
62	DBH	Mental Health - DBH Failed Claims	$20,065.90	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$20,065.90	N/A	$0.00	Moderate Risk
63	DBH	Mental Health - DBH Failed Claims	$2,748.55	Lack of documentation to support services billed	$2,748.55	N/A	$0.00	Moderate Risk
64	DBH	Mental Health - DBH Failed Claims	$7,904.65	Lack of documentation to support services billed	$7,904.65	N/A	$0.00	Moderate Risk
65	DBH	Mental Health - DBH Failed Claims	$1,575.66	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,575.66	N/A	$0.00	Moderate Risk
66	DBH	Mental Health - DBH Failed Claims	$1,757.60	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$1,757.60	N/A	$0.00	Moderate Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2017	DHCF Identified Risk Level (Limited, Moderate or High)
67	DBH	Mental Health - DBH Failed Claims	$14,842.20	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$14,842.20	N/A	$0.00	Moderate Risk
68	DBH	Mental Health - DBH Failed Claims	$2,423.33	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$2,423.33	N/A	$0.00	Moderate Risk
69	DBH	Mental Health - DBH Failed Claims	$11,413.04	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$11,413.04	N/A	$0.00	Moderate Risk
70	DBH	Mental Health - DBH Failed Claims	$545.08	Lack of documentation to support services billed	$545.08	N/A	$0.00	Moderate Risk
71	DBH	Mental Health - DBH Failed Claims	$1,922.57	Lack of documentation to support services billed	$1,922.57	N/A	$0.00	Moderate Risk
72	DBH	Mental Health - DBH Failed Claims	$329.55	Lack of documentation to support services billed	$329.55	N/A	$0.00	Moderate Risk
73	DBH	Mental Health - DBH Failed Claims	$1,728.81	Lack of documentation to support services billed	$1,728.81	N/A	$0.00	Moderate Risk
74	DBH	Mental Health - DBH Failed Claims	$9,023.63	Lack of documentation to support services billed	$9,023.63	N/A	$0.00	Moderate Risk
75	DBH	Mental Health - DBH Failed Claims	$1,453.68	Lack of documentation to support services billed	$1,453.68	N/A	$0.00	Moderate Risk
76	DBH	Mental Health - DBH Failed Claims	$1,501.08	Lack of documentation to support services billed	$1,501.08	N/A	$0.00	Moderate Risk
77	DBH	Mental Health - DBH Failed Claims	$38.04	Lack of documentation to support services billed	$38.04	N/A	$0.00	Moderate Risk
78	DBH	Mental Health - DBH Failed Claims	$297.76	Improper coding	$297.75	N/A	$0.00	Moderate Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2017	DHCF Identified Risk Level (Limited, Moderate or High)
79	DBH	Mental Health - DBH Failed Claims	$11,311.25	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$11,311.25	N/A	$0.00	Moderate Risk
80	DBH	Mental Health - DBH Failed Claims	$597.82	Improper Documentation	$597.82	N/A	$597.82	Moderate Risk
81	DBH	Mental Health - DBH Failed Claims	$3,322.35	No treatment plan to cover DOS.	$3,322.35	N/A	$3,322.35	Moderate Risk
82	DBH	Mental Health - DBH Failed Claims	$6,052.22	Lack of documentation to support services billed	$6,052.22	N/A	$6,052.22	Moderate Risk
83	DBH	Mental Health - DBH Failed Claims	$6,697.22	Lack of documentation to support services billed	$6,697.22	N/A	$6,697.22	Moderate Risk
84	DBH	Mental Health - DBH Failed Claims	$130.27	Lack of documentation to support services billed	$103.27	N/A	$0.00	Moderate Risk
85	DBH	Mental Health - DBH Failed Claims	$2,904.03	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$2,904.03	N/A	$0.00	Moderate Risk
86	IDD/Waiver (ICF/MR)	PERM	$4,239.98	The documentation submitted does not support the claim that was paid in accordance with State policy.	$4,239.98	N/A	$4,239.98	Moderate Risk
87	IDD/Waiver (ICF/MR)	PERM	$4,128.70	The documentation submitted does not support the claim that was paid in accordance with State policy.		N/A	$2,064.34	Moderate Risk
88	DBH	Mental Health - DBH Failed Claims	$3,704.73	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$3,704.73	N/A	$0.00	Moderate Risk
89	DBH	Mental Health - DBH Failed Claims	$10,428.67	Lack of documentation. Invalid treatment plan. Provider signature not dated. Encounter note does not substantiate units billed.	$10,428.67	N/A	$0.00	Moderate Risk
90	DBH	Mental Health - DBH Failed Claims	$536.25	Service improperly bulled, coding issue; Should be H2025	$536.25	N/A	$0.00	Moderate Risk
91	DME	DME	$75.00	Billed for services with no referring physician			$0.00	High Risk

Index #	Provider Type	Audit Focus	Proposed Recoupment Amount	Summary of Identified Deficiencies (Brief)	Final Recoupment Amount	Revised Final Recoupment Amount	Amount Recovered to Date FY2017	DHCF Identified Risk Level (Limited, Moderate or High)
92	DME	DME	$165,460.37	Claims not submitted under referring Provider			$0.00	High Risk
93	DME	DME	$45,000.96	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.	$1,048.20	N/A	$0.00	High Risk
94	DME	DME	$267.68	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.			$0.00	High Risk
95	DME	DME	$6,194.85	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.			$0.00	High Risk
96	DME	DME	$43,398.69	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.			$0.00	High Risk
97	DME	DME	$70,896.54	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.			$0.00	High Risk
98	DME	DME	$59.36	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.			$0.00	High Risk
99	DME	DME	$370,959.83	Billed for services under their Provider ID# as the referring Provider. Did not provide the information for the actually referring provider for the recipient per DHCF Transmittal-12-22.			$0.00	High Risk

DEPARTMENT OF HEALTH CARE FINANCE

Q26. For each waiver program, please provide the following information for FY16 and FY17, to date:

a. Services provided and eligibility requirements, including a description of and reason for any change or planned change in FY16 or FY17;
b. Reimbursement rates and methodologies, including a description of and reason for any change or planned change in FY16 or FY17;
c. Enrollment, spending/costs, and utilization data by service provided, and cost per enrollee, both current and projected, including statistical information by race, gender, ethnicity and ward; and
d. Enrollment cap, number of vacancies, number of people on the waiting list, if applicable;

Response:

The District has the following waivers:

- The Elderly & Persons with Physical Disabilities (EPD) waiver;
- The Intellectual Disabilities and/or Developmental Disabilities (ID/DD) waiver; and
- The Money Follows the Person (MFP) Deinstitutionalization Demonstration;

For the EPD Waiver Program:

Services provided and eligibility requirements including a description of and reason for any change or planned change in FY16 or FY17

To be eligible for the Elderly and Individuals with Physical Disabilities (EPD) waiver program, beneficiaries shall:

- Require the level of care furnished in a nursing facility as determined by DHCF's designee;
- Agree to participate in the waiver program by signing a Waiver Beneficiary Freedom of Choice form to elect to receive services in a home and community based setting rather than an institutional setting;
- Be aged 65 or older, or are aged 18 and older with one or more physical disabilities;
- Not be inpatients of a hospital, nursing facility or intermediate care facility;
- Be financially eligible for long term care services and supports; and
- Reside in the District of Columbia in a community setting such as a natural home or an approved EPD Waiver assisted living facility.

To be financially eligible, the individual either must be eligible for Medicaid because they are on SSI, or they cannot have income above 300% of the SSI limit ($2,205/month in 2017). In addition, the individual cannot have countable assets greater than $4,000. A home is not a countable asset.

Specific service eligibility criteria for the following home and community-based waiver services included in the Elderly and Individuals with Physical Disabilities (EPD) waiver is as follows:

- Personal care aide services

To be eligible for personal care aide services, each beneficiary shall have an assessed need for PCA services as established by the conflict-free assessment that cannot be met by State Plan PCA services alone.

- Personal Emergency Response System (PERS) services

To be eligible for PERS a person must be able to: (a) understand and demonstrate proper use of the system; or (b) live with a person who assumes responsibility for providing care (to the beneficiary) and the waiver beneficiary is subsequently not left alone for significant periods of time.

- Respite services

To be eligible for Respite services, the services must relieve the beneficiary's primary unpaid caregiver to provide a range of activities associated with the Personal Care Aide role.

- Homemaker services

To be eligible for Homemaker services, the services shall only be provided in cases where neither the beneficiary nor anyone else in the household (i.e. an unpaid family caregiver) is able to provide or deliver the service.

- Chore aide services

To be eligible for Chore aide services, the services shall only be provided in cases where the beneficiary is in need of heavy household duties including: (a) washing windows and walls; (b) tacking down loose rugs and tiles; (c) moving items or furniture in order to provide safe access and egress; (d) trash removal; and (e) removal of animal waste.

- Assisted living services

To be eligible for Assisted Living services, the person shall need personal care and supportive services furnished to persons in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet any scheduled or unpredictable resident needs and to provide supervision, safety, and security.

- Environmental Accessibility Adaptation (EAA)

To be eligible for EAA, the case manager shall ensure that a home adaptation assessment is conducted by a licensed physician, occupational therapist, or physical therapist per a physician's order, prior to ordering EAA service(s) included under the beneficiary's PCSP. Additionally, the case manager shall ensure that homeowners seeking EAA services shall only be approved or reimbursed if the person does not qualify for similar services under the Handicap Accessibility Improvement Program (HAIP) administered by the District of Columbia Department of Housing and Community Development (DHCD). The case manager shall ensure that in the case of rental property or leased property, no EAA services shall be approved or reimbursed unless: (a) the current rental, lease agreement, or other residential agreement governing the person's current residence is thoroughly examined by the Case Manager and DHCF or its designee to determine that the services are not the responsibility of the property owner or manager; and (b) a signed release was obtained from the management of the property authorizing the EAA home modifications to be made.

- Adult Day Health services

Adult day health services shall be provided to those individuals enrolled in the EPD Waiver who live in the community by offering non-residential medical supports and supervised, therapeutic activities in an integrated community setting, to foster opportunities for community inclusion, and to deter more costly facility-based care.

- Physical Therapy

To be eligible for reimbursement, each Medicaid provider must obtain prior authorization from the DHCF or its designee. In its request for prior authorization, the Medicaid provider shall document the following: (a) the EPD Waiver beneficiary's need for physical therapy services as demonstrated by a physician's order; and (b) the name of the professional or home care agency that will provide the physical therapy services.

- Occupational Therapy

To be eligible for reimbursement, each Medicaid provider must obtain prior authorization from the DHCF or its designee. In its request for prior authorization, the Medicaid provider shall document the following: (a) the EPD Waiver beneficiary's need for occupational therapy services as demonstrated by a physician's order; and (b) the name of the professional or home care agency that will provide the occupational therapy services.

- Individual-Directed Goods and Services

To be eligible for individual-directed goods and services, the EPD Waiver beneficiary must be enrolled in the Participant Directed Services (PDS) program, *Services My Way*, and the goods and services must be purchased from the participant's participant-directed service budget.

- Participant-Directed Community Supports (PDCS).

To be eligible for PDCS services, the EPD waiver beneficiary must be enrolled as participants in the Participant Directed Services (PDS) program, *Services My Way*. The beneficiary must also choose a qualified participant directed worker to provide PDCS.

Description of changes to be implemented in FY17

- DHCF is streamlining eligibility for all Long Term Care Services and Supports:

Currently EPD Waiver eligibility is determined via a paper review conducted by DCHF's agent. In order to streamline eligibility for all Long Term Care Services and Supports, including the EPD Waiver, general eligibility will be determined by requiring the level of care furnished in a nursing facility to be determined by DHCF's Long Term Care Services and Supports Contractor via a face-to-face assessment using a standardized assessment tool.

- DHCF will also add a new service (Community Transition Services) in FY17:

Community Transition Services are non-recurring set-up expenses for beneficiaries who are transitioning from an institution or other long term care facility to a more integrated and less restrictive community setting. Allowable expenses are those necessary to enable an individual to establish a basic household that does not constitute room and board such as rental application fees, household furnishings, one-time cleaning and pest-eradication fees, and set up fees or deposits for utilities. The addition of the Community Transition Services benefit will facilitate a person's transition to the community from a long term care facility setting by facilitating access to essential services to enhance the person's ability for a smooth and successful return.

Reimbursement rates and methodologies, including a description of and reason for any change or planned change in FY16 or FY17

Please see Attachment 1 to Q26 for the reimbursement rates for the EPD Waiver Year 5.

In FY 2016, DHCF received approval for several EPD waiver amendments for service changes and updates to the reimbursement methodologies that were effective October 20, 2015. Specifically, new reimbursement methodologies and rates were developed for three new EPD waiver services: occupational therapy (OT), physical therapy (PT) and Adult Day Health Program (ADHP).

Given that the rates for PCA EPD waiver services were adjusted to align with the PCA rates under the state plan benefit, the PCA EPD services rates were equally adjusted to ensure compliance with the District's Living Wage Act announced by the Department of Employment Services (DOES) in January of FY 2016 and January of 2017.

Also, following DHCF's submission of the waiver renewal application to CMS on September 12, 2016, DHCF anticipates approval and commencement of the new waiver year in April 2017. Once approved by April 2017, DHCF will implement the rate changes for Assisted Living Facilities and Respite services. Further, as part of the agency's project plan, DHCF will conduct a comprehensive review of the Assisted Living facilities rates and make comprehensive changes to the program design and rate methodology.

Enrollment, spending/costs, and utilization data by service provided, and cost per enrollee, both current and projected, including statistical information by race, gender, ethnicity and ward

For EPD Waiver enrollment, spending costs, and utilization data, please refer to Attachment 3a to Q26 - Waiver costs per enrollee and Attachment 3b to Q26 -EPD enrollment by demographic for statistical information by race, gender, ethnicity and ward.

Enrollment cap, number of vacancies, number of people on the waiting list, if applicable

The enrollment cap for the number of unduplicated participants in Waiver Year 5 of the current EPD waiver, expiring April 4, 2017, is 5060.

The current enrollment is 2781 (as of January 2017), and the number of vacancies is 2279. There is no waiting list at present.

For the ID/DD Waiver Program

Services provided and eligibility requirements including a description of and reason for any change or planned change in FY16 or FY17

Any person eligible to receive Waiver services shall be a person who currently receives services from DDS/DDA and meets all of the following requirements:

(a) Has a special income level up to three hundred percent (300%) of the SSI federal benefit or be aged and disabled with income up to one hundred percent (100%) of the federal poverty level or be medically needy as set forth in 42 C.F.R. §§ 435.320, 435.322, 435.324 and 435.330;

(b) Has an intellectual disability as defined in D.C. Official Code § 7-1301.03(15A), which, when establishing qualifying intelligence quotient (IQ), includes consideration of the standard error of measurement associated with the particular IQ test, and requires adaptive deficits across at least two of the following three domains: conceptual, practical, and social;

(c) Is eighteen (18) years of age or older;

(d) Is a resident of the District of Columbia as defined in D.C. Official Code § 7-1301.03(22);

(e) Has a Level of Care (LOC) determination that the person requires services furnished in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or be a person with related conditions pursuant to the criteria set forth in DCMR § 29-1902.4; and

(f) Meets all other eligibility criteria applicable to Medicaid recipients including citizenship and alienage requirements.

A person shall meet the LOC determination set forth in DCMR § 29-1902.1(e) if one of the following criteria has been met, taking into consideration the standard error of measurement for the IQ test:

(a) The person's primary disability is an intellectual disability with an intelligence quotient (IQ) of fifty-nine (59) or less;

(b) The person's primary disability is an intellectual disability with an IQ of sixty (60) to sixty-nine (69) and the person has at least one (1) of the following additional conditions:

(1) Mobility deficits;
(2) Sensory deficits;
(3) Chronic health problems;
(4) Behavior problems;
(5) Autism;
(6) Cerebral Palsy;
(7) Epilepsy; or
(8) Spina Bifida.

(c) The person's primary disability is an intellectual disability with an IQ of sixty (60) to sixty-nine (69) and the person has severe functional limitations in at least three (3) of the following major life activities:

(1) Self-care;
(2) Understanding and use of language;
(3) Functional academics;
(4) Social skills;
(5) Mobility;
(6) Self-direction;
(7) Capacity for independent living; or
(8) Health and safety.

(d) The person has an intellectual disability, has severe functional limitations in at least three (3) of the major life activities as set forth in § 1902.4(c)(1) through § 1902.4(c)(8), and has one (1) of the following diagnoses:

(1) Autism;
(2) Cerebral Palsy;
(3) Prader Willi; or
(4) Spina Bifida.

The District's amended ID/DD Waiver (as of November 20, 2015) was authorized to provide the following home and community based waiver services:

> Creative Arts Therapies, Behavioral Supports, Day Habilitation, Dental, Employment Readiness, Environmental Accessibilities Adaptation, Family Training, Host Home, Individualized Day Supports, In-Home Supports, Occupational Therapy, One-Time Transitional Services, Personal Care Services, Personal Emergency Response System (PERS), Physical Therapy, Residential Habilitation, Respite, Companion Services,
>
> Skilled Nursing, Small Group Supported Employment, Speech-Hearing and Language Services, Supported Employment, Supported Living, Supported Living with Transportation, Vehicle Modifications, and Wellness Services.

As part of the ID/DD waiver renewal, DHCF and DDS intend to make changes to the existing waiver to: (1) respond to input from stakeholders, including program participants, family members, and providers; (2) continue to evolve the system to meet the requirements of the CMS HCBS Settings Rule by the established March 2019 deadlines; (3) make any needed changes to rate methodologies (CMS requires review of all rates as part of a waiver renewal); and (4) continue to implement best practices in the field.

Reimbursement rates and methodologies, including a description of and reason for any change or planned change in FY16 or FY17

Please see Attachment 2 to Q26 - Appendix J Year 4 for the reimbursement rates for the ID/DD waiver year 4. Although there were no changes in FY 2016, during FY 2017 DHCF will continue working with DDS on developing the waiver renewal application that will be effective in FY 2018.

Enrollment, spending/costs, and utilization data by service provided, and cost per enrollee, both current and projected, including statistical information by race, gender, ethnicity and ward

For ID/DD waiver enrollment, spending costs, and utilization data, please refer to Attachment 3a to Q26 - Waiver for costs per enrollee and Attachment 3e to Q26 for enrollment by demographic.

Enrollment cap, number of vacancies, number of people on the waiting list, if applicable

The ID/DD waiver has a capacity of 1752 for Waiver Year (WY) 5 and is currently serving approximately 1714. There is no waiting list at present.

For the Money Follows the Person Demo:

Services provided and eligibility requirements including a description of and reason for any change or planned change in FY16 or FY17

This project provides transition services to DC Medicaid beneficiaries living in long term care facilities who want to move to homes in the community. CMS recommended that the District implement MFP on a population by population basis (see below). As directed by CMS, the MFP Operational Protocol approved through FY 2010 outlined demonstration services only for people with intellectual and developmental disabilities. In October 2010, CMS approved an amendment to the MFP Operational Protocol that includes services for people who are eligible for the District's EPD Home and Community-Based Services Waiver. Subsequently, in January 2017, DHCF filed and obtained CMS approval for updates that reflect current operations.

The services are a mix of transition coordination and intensive case management provided by full-time MFP staff at the DC Office on Aging's (DCOA) Aging and Disability Resource Center (ADRC), and existing home and community-based waiver services and demonstration services.

For participants in the EPD target group there are three demonstration services:

- Payment of up to $5,000 in transition expenses related to moving and household set up. This is consistent with the One-Time Transitional Service covered under the ID/DD HCBS waiver.
- Payment of up to $10,000 in expenses related to environmental accessibility adaptations, i.e. home modifications like ramps and stair lifts. This is consistent with the Environmental Accessibility Adaptation service covered under the EPD HCBS waiver, and allows access to the service for these participants before they are discharged and enrolled in the waiver.
- Intensive total case management during the MFP Demonstration Year. This includes 24/7 care coordination and crisis management by a full-time case manager at the DCOA's ADRC. MFP participants receive demonstration services for 365 days to support their transition from institutions, e.g. Intermediate Care Facilities for people with Intellectual Disability (ICFs/ID) and Nursing Facilities (NFs), to homes in the community.

When they transition, MFP participants are also enrolled in the appropriate home and community-based services (HCBS) waiver under the MFP program code. In general, people transitioning from ICFs/ID enroll in the Intellectual Disability and Developmental Disabilities HCBS waiver, and people transitioning from nursing facilities enroll in the EPD HCBS waiver.

Eligibility requirements for enrollment into the MFP demonstration are as follows:

- Must reside (and have resided, for a period of not less than 3 months) in an inpatient facility;

- Receive Medicaid benefits for inpatient services furnished by such inpatient facility; and
- Continue to require the level of care provided in an inpatient facility but for the provision of home and community-based long-term care services.

An inpatient facility, or "Qualified Institution" under the federal Demonstration, means a hospital, nursing facility, or ICF/IDD. An institution for mental disease (IMD) is included only to the extent medical assistance is available under the State Medicaid plan for services provided by such an institution. Medicaid payments may only be applied to persons in IMDs who are over 65 and under 21.

At the beginning of FY15, DHCF transferred all program operations to the DC Office on Aging/Aging & Disability Resource Center. Oversight and monitoring activities, including reporting to CMS, remain at DHCF.

Over the next two years, MFP activities will be gradually phased out and integrated into District services. Federally funded transitions from LTC facilities to HCBS under the MFP Demonstration are scheduled to end on December 31, 2017. Demonstration funding of HCBS for all MFP participants, and intensive case management for nursing facility residents who transition will continue through the year after the last transition until December 31, 2018. DHCF and MFP operating agencies, the DC Office on Aging, and the Department on Disability Services, will complete and submit all required reporting to CMS by December 31, 2019. DHCF filed and obtained CMS approval of a sustainability plan to incorporate certain MFP benefits into the Medicaid program on a permanent basis, subject to appropriations.

Reimbursement rates and methodologies, including a description of and reason for any change or planned change in FY16 or FY17

The District receives an enhanced Federal match rate (FMAP) for MFP at 85 percent for all qualified home and community-based and demonstration services rendered during the 365 day Demonstration period. This will remain constant for the remainder of the Demonstration project through the first quarter of FY19.

Service reimbursement rates and methodologies are consistent with home and community-based services provided through the District's Medicaid State Plan and 1915(c) waiver programs (EPD and ID/DD).

Enrollment, spending/costs, and utilization data by service provided, and cost per enrollee, both current and projected, including statistical information by race, gender, ethnicity and ward

For waiver enrollment, spending costs, and utilization data, please refer to Attachment 3a – Waiver Costs per Enrollee and Attachment 3c to Q26 - MFP enrollment by demographic.

Enrollment cap, number of vacancies, number of people on the waiting list, if applicable
There are 160 reserved capacity slots remaining in the EPD Waiver for residents transitioning from nursing facilities to the community. Given that there is no longer a waiting list for the EPD Waiver program, the reserved capacity slots reserved FY12-15, at 40 per year, remain in reserve.

The Department on Disabilities Services/Developmental Disabilities Administration has a reserve in the ID/DD waiver that will accommodate the 3 planned transitions.

MFP Transition Coordinators will transition approximately 30 nursing facility residents. Service Coordinators at the Department on Disabilities Services/Developmental Disabilities Administration are slated to transition 3 residents from intermediate care facilities for people with ID/DD to home and community-based waiver services through MFP.

Lastly, the MFP demonstration project does not have a waiting list for services. The DC Office on Aging's Aging & Disability Resource Center (ADRC) maintains a record of nursing home residents who have been screened and determined eligible for MFP who also need subsidized housing to return to the community. DHCF, in collaboration with the ADRC held a lottery on February 29, 2016 to select residents from this pool for the remaining housing choice voucher set-aside for MFP participants. The remainder of the housing choice voucher set-asides are projected to be used by MFP participants in the community during 2017.

DEPARTMENT OF HEALTH CARE FINANCE

Q27. Please provide an update on the Nursing Home Quality of Care Fund. In addition to a narrative description of the spending for FY16 and to date in FY17, please include a line-item spending plan showing both revenues and expenditures for the Nursing Home Quality of Care Fund in FY16 and FY17.

Response:

Each year the Department of Health Care Finance utilizes Nursing Home Quality of Care (NHQC) funding in a similar fashion. The funds are used to: 1) cover the District's portion of the salary for an analyst dedicated to working on Nursing Facility matters; 2) pay for nursing facility audits; 3) fund MOUs with OTR and DCOA; and 4) pay a portion of the local payments made to the Nursing Facilities for services. In FY16, the District collected $12,841,663.10 and accrued $4,172,134.42 for a total of $17,013,797.52 (this number is larger than previous years based on collection of delinquent taxes). In FY17, the nursing facilities have been collectively assessed a tax of $14,768,933.31 ($5,931.30 per bed). We have collected $2,972,344.48 through December 31, 2016.

FY16 Detailed Spending

FY 2016	
Description	**Actuals**
Personal Services	70,363.78
Nursing Facility Audits	77,570.72
Rate Methodology Contract	151,800.00
Provider Payments	13,785,132.78
MOUs	1,032,132.90
Expenditure Total:	**15,117,000.18**
Revenue	**17,013,797.52**

FY17 Spending Plan & YTD Expenditures

FY 2017		
Description	**Spending Plan**	**YTD Actuals**
Personal Services	76,251.49	20,175.57
Nursing Facility Audits	450,650.75	-
Rate Methodology Contract	165,000.00	35,106.38
Provider Payments	10,627,751.93	-
MOUs	1,534,587.63	318,559.58
Expenditure Total:	**12,854,241.80**	**373,841.53**
Revenue	**12,854,241.80**	**2,972,344.48**

Note: FY17 actuals are through 12/31/2016.

DEPARTMENT OF HEALTH CARE FINANCE

Q28. Please provide an update on the Medicaid application system and any IT issues incurred in FY 16 and FY17 to date, and what steps the agency is taking to minimize the disruption of services to consumer.

Response:

The District has resolved IT issues affecting Medicaid eligibility determinations and renewals that surfaced during the roll out of the DC Access System (DCAS), the District's automated, integrated eligibility system. Phase I of the project, which focused on building and deploying the Medicaid functionality needed to determine eligibility for individuals using the new Modified Adjusted Gross Income (MAGI) standards, was launched on October 1, 2013. During FY 2016, the District resolved IT issues that were causing some applications to be "stuck" or "malformed" and eliminated virtually all case processing backlogs. The District instituted new reports to track pending applications before they exceed the case processing timeline of 45 days, and implemented new processes and technology upgrades that close cases when a beneficiary has failed to complete an application within the 45 day timeline.

With respect to renewal applications, a major system upgrade implemented in October 2016 fixed residual defects and improved renewal functionality. As a result of these improvements, during the first three months of FY 2017, the passive renewal rate averaged 89%. This means that 89% of individuals were renewed solely through an automated process that checked their eligibility against other electronic data sources – they did not have to visit a service center or submit any documentation.

In FY 2017, there have been no new IT issues identified that adversely affect beneficiary eligibility or renewals in Release 1. DHCF is currently working on the RFP for Release 3 which addresses remaining Medicaid functionality, working on data clean up and continuing to work with the Economic Security Administration on Business Process Improvements and case worker training.

DEPARTMENT OF HEALTH CARE FINANCE

Q30. Please provide a list of all State Plan Amendments (SPAs) submitted to CMS for approval in FY16 and to date in FY17. For each, please provide a narrative description, an update on its status, reason for the SPA, a detailed description of costs-savings associated with the SPA, and details of any service changes that will occur because of the SPA.

Fiscal Year Submitted	SPA Name	Purpose	Status	Service Change	Cost Savings
FY16	**Penalty Period for Asset Transfers**	Federal law requires an individual seeking enrollment in Medicaid to disclose their assets during the eligibility determination process for long-term care services. If assets have been transferred for less than fair market value during the applicable period, a penalty period will be calculated during which the applicant is not eligible for Medicaid reimbursement of long-term care services. States may calculate the penalty period based on the cost of private pay nursing facility services across the state, or in the local community. The District submitted this SPA to elect the statewide option for the penalty period calculation.	Approved 11/10/15	N/A	None
FY16	**Childless Adult Expansion 134 - 210% FPL**	Converts the District's prior Section 1115 waiver childless adult eligibility group for individuals aged 21-64 years with incomes from 134 – 210% FPL to a State Plan eligibility group. Making this change	Approved 11/20/15	N/A (the District previously covered this eligibility group under a Section 1115 waiver)	None

Fiscal Year Submitted	SPA Name	Purpose	Status	Service Change	Cost Savings
		allowed the District to retain eligibility for this group without obtaining federal approval for a Section 1115 waiver demonstration program.			
FY16	**Outpatient Hospital Services Supplemental Payment**	Maintains the District's ability to provide supplemental payments to eligible District hospitals that participate in the Medicaid program from October 1, 2015 through September 30, 2016.	Approved 2/4/16	N/A	None
FY16	**Primary Care Rate Increase Permanent Extension**	Permanently maintains reimbursement rate at 100% of Medicare rates for certain primary care services provided by qualified physicians and advanced practice registered nurses. These rate increases were originally mandated by the Affordable Care Act for previous calendar years. The District opted to continue these enhanced payments and in addition, with this SPA, obtained authority to expand the definition of eligible providers to include psychiatrists and obstetricians/gynecologists.	Approved 2/1/16 Effective 1/1/16	This SPA expands service delivery to qualified advanced practice registered nurses, as well as qualified physicians. Both will deliver services based upon their scopes of practice and in accordance with rules and regulations promulgated by the District of Columbia Health Occupations Board.	None
FY16	**Temporary Residency; State Residency for IV-E Foster Care Children**	Establishes parameters for enrollment in the District Medicaid program for otherwise eligible individuals who are District residents and temporarily residing in another state. Includes guidelines for Medicaid coverage of Title IV-E foster care children placed in care outside of the District.	Approved 4/27/16 Effective 4/1/16	N/A	None

Fiscal Year Submitted	SPA Name	Purpose	Status	Service Change	Cost Savings
FY16	**Katie Beckett Cost-Effectiveness Methodology**	Establishes the cost-effectiveness methodology for the District Medicaid program to use in determining whether a child is eligible through the "Katie Beckett" eligibility pathway for children with an institutional level of care need for whom treatment at home is safe and more cost-effective than treatment in an institution.	Approved 5/27/16 Effective 1/1/16	N/A	None
FY16	**Reimbursement of Chemotherapy Drugs**	Authorizes the District to reimburse chemotherapy drugs that are administered on or after May 1, 2016 at one hundred percent (100%) of the Medicare fee schedule.	Approved 6/27/16 Effective 5/1/16	N/A	None
FY16	**Dental Services**	Clarifies criteria for dental services and limitations for adults and children. Identifies the criteria beneficiaries must satisfy in order to obtain prior authorization for the delivery of orthodontia services to child beneficiaries under twenty-one (21) years old and expands the provider types that can attest to the need for these orthodontia services. The SPA also corrects the description of service limitations for dentures, clarifying that coverage of dental prostheses is available to adult beneficiaries.	Approved 10/4/16 Effective 11/1/16	Corrects description of service limitations for dentures to clarify that District Medicaid provides coverage for both pediatric and adult beneficiaries.	None
FY16	**Outpatient Hospital Services Supplemental Payment**	Continues the District's ability to provide supplemental payments to eligible District hospitals that participate in the Medicaid program through September 30, 2017.	Approved 11/8/16 Effective 10/1/16	N/A	None
FY16	**Nursing Facility Reimbursement - Inflation Elimination**	Eliminates the annual inflation adjustment for nursing facilities' reimbursement methodology for Fiscal Year 2017 and all	Approved 11/22/16 Effective 10/1/16	N/A	FY17 estimated local cost savings: $1,370,804

Fiscal Year Submitted	SPA Name	Purpose	Status	Service Change	Cost Savings
		years thereafter.			
FY16	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Reimbursement - Inflation Elimination**	Eliminates the annual inflation adjustment for ICF/IID reimbursement methodology for Fiscal Year 2017 and all years thereafter, in line with the District's long-term budget priorities.	Approved 11/22/16 Effective 10/8/16	N/A	FY17 estimated local cost savings: $500,000
FY16	**Asset Verification System**	Provides approval for and delineates the process for the District's implementation of an electronic Asset Verification for Medicaid, which will enable the District to electronically verify assets for individuals applying for eligibility for Medicaid long-term services and supports.	Approved 1/18/16 Effective 10/1/16	N/A	None
FY16	**Federally Qualified Health Center (FQHC) Reimbursement Methodology**	Establishes a new reimbursement methodology for FQHCs that participate in the District's Medicaid program, including updated prospective payment system (PPS) rates and procedures and a new set of four alternative payment methodology (APM) rates for primary medical care, behavioral health services, preventive and diagnostic dental, and comprehensive dental services. This SPA also establishes a new performance-based payment system which will require FQHCs to meet certain standards, provide quarterly reports, and assess performance based on three key measures, enabling FQHCs that qualify to receive additional performance-based payments annually, and beginning on January 1, 2018.	Submitted 8/22/16	Allows FQHCs to bill on the same day for up to three service types for the same beneficiary (primary medical, behavioral and dental services). Also allows FQHCs to receive reimbursement for certain services provided through mobile units or in the home.	None

Fiscal Year Submitted	SPA Name	Purpose	Status	Service Change	Cost Savings
FY16	**Private Duty Nursing Services**	Establishes eligibility criteria and provider requirements for private duty nursing, a more intensive skilled nursing service benefit offered under the State Plan home health benefit.	Submitted 9/30/16	Supplements existing guidance regarding eligibility criteria and provider requirements for private duty nursing services currently provided under the State Plan.	None
FY16	**Home Health Services**	Clarifies amount, duration, and scope of services offered under the State Plan home health benefit.	Submitted 9/30/16	Supplements existing guidance regarding provider requirements and service delivery parameters for home health services currently provided under the State Plan.	None
FY17	**Health Home II (My Health GPS)**	Establishes criteria for participation in a new health home initiative to provide intensive care coordination and social supports for beneficiaries with multiple chronic conditions.	Approved 2/6/17 Effective 7/1/17	Creates new set of comprehensive care coordination services offered to beneficiaries with multiple chronic conditions.	None
FY17	**Personal Care Aide (PCA) Services**	Makes technical correction to definition of scope of services allowable under State Plan Personal Care Aide (PCA) services to individuals with an institutional level of clinical need in accordance with sufficiency data analysis submitted by DHCF to CMS.	Submitted 2/9/17	N/A	None

DEPARTMENT OF HEALTH CARE FINANCE

Q31. Please provide a list of planned SPAs for FY17. For each, please provide a narrative description and a projected timeline for Council and CMS submission. Please also provide a detailed description of costs-savings associated with the SPA and details of any service changes that will occur because of the SPA.

Response:

Fiscal Year	SPA Name	Purpose	Projected Timeline	Service Changes	Cost-Savings
FY17	Covered Outpatient Drugs	Implements a new reimbursement methodology that complies with the new Centers for Medicare and Medicaid Services (CMS) final rule requiring certain drug ingredient costs to be reimbursed at actual acquisition cost. This SPA also increases professional dispensing fees.	Council: Approved in FY17 BSA CMS: April 2017	N/A	FY 2017 (Prorated 50% from April 1 $3,217,368) FY 18, Full (6,434,735)
FY17	Hospice	Updates standards for the delivery of and reimbursement for adult hospice services, enabling DHCF to maintain compliance with new federal requirements regarding payment rates for routine home care services and increase monitoring and oversight of delivery of hospice services	Council: June 2017 CMS: July 2017	Provides additional guidance regarding the concurrent receipt of Personal Care Aide (PCA) services and services offered through the Home and Community-Based Services (HCBS) Waiver for the Elderly and Persons with Physical Disabilities (EPD Waiver) by beneficiaries who elect hospice.	None

Fiscal Year	SPA Name	Purpose	Projected Timeline	Service Changes	Cost-Savings
FY17	ICF/IID - Reimbursement Adjustments	Implements three changes related to reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID): (1) redistribution of paid bedhold days; (2) extending assessment periods for low-acuity beneficiaries; and (3) increasing flexibility in re-allocation of unspent reimbursement funds among cost centers.	Council: Approved in FY17 BSA CMS: June 2017	N/A	Not yet determined
FY17	Nursing Facilities - Reimbursement Methodology	Redesigns reimbursement methodology for nursing facilities, including new quality measures and potential for value-based purchasing.	Council: Approved in FY17 BSA CMS: September 2017	N/A	Not yet determined
FY17	PCA - Safety Monitoring and Annual Reassessment	Adds safety monitoring as an allowable task for PCAs and aligns reassessment process with the EPD Waiver Renewal.	Council: March 2017 CMS: April 2017	Streamlines reassessment process for continued service eligibility to relieve administrative burden on beneficiaries and DHCF.	No cost savings
FY17	Pharmacist Administration Services	Authorizes DHCF to reimburse pharmacies an administration fee for pharmacists that administer immunizations, vaccines, and anaphylaxis agents.	Council: May 2017 CMS: June 2017	Pharmacists would be able to directly administer immunizations, vaccines and anaphylaxis agents to Medicaid beneficiaries.	No Cost-Savings

Fiscal Year	SPA Name	Purpose	Projected Timeline	Service Changes	Cost-Savings
FY17	Youth Substance Abuse and Treatment Services	Authorizes coverage of substance use disorder treatment delivered to Medicaid-enrolled youth under new Youth Substance Abuse and Treatment Services (YSATS) program (to replace current Adolescent Substance Abuse Treatment Expansion Program (ASTEP)). Replicates Adult Substance Abuse and Rehabilitative Services (ASARS), and would also be managed by DC Department of Behavioral Health (DBH).	Council: June 2017 CMS: July 2017	The SPA clearly defines the substance use disorder (SUD) services available to vulnerable youth with SUD,	Not yet determined
FY17	School-based Health Services	Clarifies scope of Medicaid reimbursement available for services provided to Medicaid-enrolled students receiving medical services at District schools, regardless of whether children have an individualized education plan. Would enable District Medicaid program to reimburse for services previously considered "free care" under CMS Free Care guidance.	Council: June 2017 CMS: July 2017	TBD	Not yet determined

DEPARTMENT OF HEALTH CARE FINANCE

Q32. Identify and describe any current or planned participation in any demonstration projects in FY16 and FY17, to date.

Responses:

DHCF participated in the following demonstrations in FY16 and in FY17:

- Section 1115 Childless Adult Demonstration: This demonstration provided Medicaid coverage to adults with no dependent children and with incomes between 133% and 200% of the Federal Poverty Level (FPL). The Demonstration ended on December 31, 2015. To ensure that individuals in this coverage group continued to be eligible for Medicaid, DHCF sought and obtained approval of a new state plan amendment establishing a new coverage group for adults with no dependent children at the same income thresholds as the Childless Adult Demonstration. All beneficiaries who were covered under the 1115 Childless Adult Demonstration were seamlessly transitioned to the new coverage group effective January 1, 2016.

- Money Follows the Person (MFP) Demonstration: This time-limited demonstration provides transition services to DC Medicaid beneficiaries living in long-term-care facilities who want to move to homes in the community. In 2010, CMS approved the District's MFP Operational Protocol (OP) to transition people from nursing facilities with home and community-based supports (HCBS) through DC Medicaid's Elderly and Physical Disability (EPD) Waiver Program. The Project also assists people with intellectual and developmental disabilities (IDD) to transition from Intermediate Care Facilities with HCBS through DC Medicaid's IDD Waiver Program. Through the Affordable Care Act, funding for the MFP Program was extended through September 30 2016, Any funds remaining at the end of each fiscal year carry over to the next fiscal year, and can be used to make grant awards to current and new grantees through FY 2016. Any unused grant funds awarded in 2016 can be used through FY 2020. In January 2017, DHCF filed and obtained CMS approval for updates to the OP that reflect current operations. Over the next two years, as grant funding is expended, MFP activities will be gradually phased out and integrated into District services. Federally funded transitions from LTC facilities to HCBS under the MFP Demonstration are scheduled to end on December 31, 2017. Demonstration funding of HCBS for all MFP participants, and intensive case management for nursing facility residents who transition will continue through the year after the last transition until December 31, 2018. DHCF and MFP operating agencies, the DC Office on Aging and Department on Disability Services, will complete and submit all required reporting to CMS by December 31, 2019. DHCF filed and obtained CMS approval of a sustainability plan to incorporate certain MFP benefits into the Medicaid program on a permanent basis, subject to appropriations.

DEPARTMENT OF HEALTH CARE FINANCE

Q36. Please explain in detail the current status of DHCF's collaboration with the Department of Behavioral Health regarding obtaining Medicaid funding for new evidence-based practices.

The Department of Health Care Finance, in collaboration with the Department of Behavioral Health (DBH), submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) that would authorize the delivery of evidence-based practice services to Medicaid-eligible children in the District. These services include Child-Parent Psychotherapy for Family Violence (CPP-FV) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The SPA received approval on November 19, 2014. On December 4, 2015, DHCF published an emergency and proposed rule establishing rates for these two evidence-based practices. These rules were effective on November 25, 2015.

DEPARTMENT OF HEALTH CARE FINANCE

Q43: Please provide an analysis on enrollment in the Alliance program since the recertification process has required members to recertify face-to-face, every six months. What percentage of people have been terminated from the program each year since this requirement has been in place? Does the agency believe that this has cut down on fraud, and if so, by how much? Has there been discussion on transitioning to a yearly recertification process?

Response:

1. Terminations

DHCF implemented the six-month, face-to-face recertification process in October 2011, the first month of fiscal year (FY) 2012. Since that time, enrollment in the Alliance program has been relatively stable, with monthly enrollment averaging 15,000 individuals.

The table below provides the number of beneficiaries who were enrolled each September between 2012 and 2016, the number of terminations in each of those months, and the percentage of terminations out of the number enrolled. Monthly termination percentages are a more accurate indicator than annual totals, which are not cumulative. For example, a considerable proportion of the number of Alliance beneficiaries who were terminated each month were re-enrolled with their previous MCO within 60 days; for some MCOs in some months, as many as 50 percent of new enrollees in a given month were those who had been terminated within the past 60 days but later reenrolled.

DC Alliance Enrollment Analysis, FY12-FY16

Month	Alliance monthly enrollment	Monthly disenrollment	Percent terminated from coverage
Sep-12	16,021	1,914	12%
Sep-13	14,813	1,698	11%
Sep-14	15,272	1,570	10%
Sep-15	15,788	1,866	12%
Sep-16	15,318	1,696	11%

2. Fraud

The intention of the six-month, face-to-face recertification requirement in the Alliance program was to increase accountability for District residency and deter non-resident enrollment. Although the recertification process has certainly reduced fraud in the program, it has been difficult to quantify precisely how effective the program has been. Thus, DHCF and the Department of Human Services Economic Security Administration (ESA) convened an Alliance Program Interagency Workgroup in May 2016 to gain a deeper understanding of program experience with fraud, the root causes of rising program costs, the enrollment experience, and churn (the experience of individuals disenrolling and reenrolling in coverage).

As part of this work, DHCF conducted a risk analysis for non-resident enrollment in the Alliance program. While the preliminary results suggest that the risk of non-resident enrollment should remain a concern, they inconclusive and will require additional analysis.

As with all of its programs, DHCF continues to explore cost-effective options for reducing fraud in the Alliance program while ensuring that all eligible residents are able to obtain health coverage in an efficient and timely manner. Please see response to Question 49 for a discussion of the potential increase in programmatic costs if the 6-month recertification period was changed to 12 months.

DEPARTMENT OF HEALTH CARE FINANCE

Q44: In FY 2016, what percent and number of Alliance beneficiaries were returning beneficiaries (as opposed to those who were never before enrolled)? Does DHCF track the amount of time that these beneficiaries were without insurance between their termination and reenrollment? If so, what is the average amount of time without insurance?

Response:

In FY 2016, 21,941 individuals were enrolled in Alliance at some point during the year. To identify the percentage of those who were returning, DHCF identified their current span of enrollment, which may have begun in FY2016 or in an earlier year. We then identified how many of those individuals had been enrolled in the program at some point prior to their current enrollment span. Of the 21,941 total enrollees in FY2016, 14,391, or 66 percent, were enrolled in the program at some point prior to their current enrollment span. In contrast, 7,550 of those 21,941 individuals, or 34%, had never been in the program before.

DHCF does not track the amount of time that beneficiaries who leave the Alliance program and later return were uninsured during the period of time they were not in Alliance.

DEPARTMENT OF HEALTH CARE FINANCE

Q46: How many Alliance recertification cases are terminated for failure to complete the interview requirement? How many cases are terminated for failure to turn in documentation, including the renewal form?

Response:

The Department of Human Services' Economic Services Administration (ESA) conducts eligibility determinations for the Alliance program through the District's legacy electronic eligibility system, the Automated Client Eligibility Determination System (ACEDS). ACEDS does not have the capability to track the specific reasons for terminations, and, to date, this information has not been tracked in any other way. Without documented information on reasons for disenrollment, it is impossible to determine how many cases are terminated due to a failure to interview or return a renewal form. DHCF is considering other means to determine why an individual is terminated at renewal based on qualitative input from Alliance enrollees (e.g., through a phone survey, focus groups, and/or other means).

DEPARTMENT OF HEALTH CARE FINANCE

Q47: How many Alliance recertification cases are terminated for failure to complete the interview requirement? How many cases are terminated for failure to turn in documentation, including the renewal form?

Response:

See response for question #46.

DEPARTMENT OF HEALTH CARE FINANCE

Q49: Previous DHCF estimates suggest that switching the Alliance 6-month recertification to one year would increase programmatic costs by $10-$15 million per year. What is this analysis based on? Is this estimate still accurate to the best of DHCF's understanding? If so, has the basis for the estimate changed from the previous ones? If so, how?

Response:

The Office of the Chief Financial Officer (OCFO) prepares cost estimates for the Department of Health Care Finance and conducted previous estimates on the cost of eliminating the 6 month face-to-face recertification and replacing with a one year recertification.

Those estimates were based on the additional cost of care for Alliance beneficiaries whose enrollment would have ended at their 6-month recertification, but is extended another six months due to the shift in recertification period. Those beneficiaries effectively get six additional months of Alliance coverage. Having estimated the number of months of additional coverage, the cost was then multiplied by the forecasted weighted average capitation rate for the Alliance plus the average monthly cost of the pharmacy benefit and the average monthly local cost of the emergency hospital benefit. Using this process, the previous estimate FY17 cost estimate of eliminating the 6 month face-to-face recertification period was an additional annual cost of $14.3 million.

Since that estimate was created, the OCFO revised the estimate using more recent Alliance enrollment projections and the actual FY 2017 weighted average capitation rate for the Alliance. The estimated annual impact us now $14.9 million – an approximately $600,000 increase from the previous estimate.

DEPARTMENT OF HEALTH CARE FINANCE

Q51. Please provide information about any work DHCF is doing with DBH and DC's education agencies to resolve concerns about payments for the educational part of PRTF placements, for youth with and without Individualized Education Plans (IEPs) from the school. Please provide any MOAs or MOUs related to this subject.

Response:

See response for question #35.

DEPARTMENT OF HEALTH CARE FINANCE

Q53. For children in Medicaid MCOs and IDEA Part C Early Intervention Services, please provide the number of such children broken down by MCO, number of different therapy companies utilized per child, and wait time before each therapy service is provided.

Response:

Please see below. All wait-times vary depending on the type of service, and are contingent upon receipt of a signed/authorized Individual Family Service Plan (IFSP).

AmeriHealth

Number of Unique Enrollees Receiving Services in FY16	Average Wait-Times	Early Intervention Providers
192	Occupational, Physical, and Speech Therapy: 24 Days Special Instruction, Developmental Therapy, and Applied Behavioral Analysis: 22 Days	1. Behavioral & Educational Services 2. Coastal Healthcare Service 3. Connections Therapy Center 4. DC Therapy Solutions 5. Easter Seals 6. Healing Hands 7. Pediatric Therapy 8. Jacob's Promise 9. Kids In Motion 10. Milestone Therapeutic Services 11. Multicultural Rehab 12. National Speech Language 13. NCC 14. Optimal Beginnings 15. Sunrise 16. The Sparks Group

MedStar

Number of Unique Enrollees Receiving Services in FY16	Average Wait-Times	Early Intervention Providers
112	Initial Evaluation: 12 Days From Initial Evaluation to Rendering of Services: 15 Days	1. Basic ABA 2. Behavioral & Educational Solutions 3. Capitol ABA LLC 4. Coastal Healthcare Pediatric Services 5. Connections Therapy 6. Easter Seals 7. Epic Developmental Services 8. Impressions Therapy Center *(formerly LKM)* 9. Interactive Therapy Group 10. Jacob's Promise 11. Kids in Motion 12. Little Feet & Hands 13. Milestone Therapeutics 14. Multicultural Rehab 15. National Children's Center 16. National Speech/Language Center 17. Pediatric Speech Lab 18. Play-Based Physical Therapy Inc. 19. Skills on the Hill 20. Sunrise 21. The S.P.A.R.K.S. Group LLC 22. Washington Pediatric Therapy

Trusted		
Number of Unique Enrollees Receiving Services in FY16	**Average Wait-Times**	**Early Intervention Providers**
311	After Receipt of Request: 30 Days	1. Care Resources 2. Coastal Healthcare 3. Connections Therapy 4. Early Start Speech & Language Services, LLC 5. Easter Seals 6. EPIC Developmental Resources 7. Impressions Pediatric Therapy 8. Jacob's Promise 9. Kids in Motion 10. Lt. Joseph P. Kennedy Institute 11. Milestone Therapeutic Services - DC 12. Multicultural Rehab 13. National Children's Center 14. National Speech Therapy - Rockville, MD 15. Sunrise Therapy - MD and DC 16. The Sparks Group - MD

Fee-for-Service	FY 2016
Total number of enrollees receiving prescriptions	41,787
Total number of prescriptions	1,061,569
Total number of prior authorization requests	15,062
Total number of prior authorizations approved	13,459
Total number of Hepatitis C drug class prescriptions filled by plan	965
Total amount paid for Hepatitis C drug class prescriptions	$29,384,547.00
Total number of HIV DCPPN prescriptions (10/01/15 to 04/29/16)*	43,590
Total amount paid for HIV DCPPN prescriptions (10/01/15 to 04/29/16)*	$21,469,386.00
Total number of HIV FFS prescriptions filled (04/30/16 to 09/30/16)*	33,118
Total amount paid for HIV FFS prescriptions (04/30/16 to 09/30/16)*	$54,266,557.00
Total number of Prescriptions from PDL	682,751
Percentage of prescriptions from PDL vs. Total number of prescription filled	64.32%
Total Cost of FFS Prescriptions	$187,371,149.00

Managed Care	FY 2016
AMERIHEALTH CARITAS DC	
Total number of enrollees receiving prescriptions	70,254
Total number of prescriptions	812,122
Total number of prior authorization requests	7,330
Total number of prior authorizations approved	4,159
Total number of Hepatitis C drug class prescriptions filled by plan	106
Total amount paid for Hepatitis C drug class prescriptions	$3,305,367.81
Total number of HIV/AIDS drug class prescriptions filled by plan	0
Total amount paid for HIV/AIDS drug class prescriptions	$0.00
Total number of Prescriptions from Formulary	829,723
Percentage of prescriptions from Formulary vs. Total number of prescription filled	97.97%
Total Cost of **AMERIHEALTH CARITAS DC** Prescriptions	$40,345,252.00
MedStar Family Choice	
Total number of enrollees receiving prescriptions	11,906
Total number of prescriptions	444,823
Total number of prior authorization requests	3,584
Total number of prior authorizations approved	3,340
Total number of Hepatitis C drug class prescriptions filled by plan	239
Total amount paid for Hepatitis C drug class prescriptions	$7,544,714.60
Total number of HIV/AIDS drug class prescriptions filled by plan	0
Total amount paid for HIV/AIDS drug class prescriptions	$0.00
Total number of Prescriptions from Formulary	435,739
Percentage of prescriptions from Formulary vs. Total number of prescription filled	97.96%
Total Cost of MedStar Prescriptions	$34,787,738.00
Trusted Health	
Total number of enrollees receiving prescriptions	18,093
Total number of prescriptions	208,072
Total number of prior authorization requests	2,226

Total number of prior authorizations approved	2,048
Total number of Hepatitis C drug class prescriptions filled by plan	86
Total amount paid for Hepatitis C drug class prescriptions	$1,796,234.74
Total number of HIV/AIDS drug class prescriptions filled by plan	0
Total amount paid for HIV/AIDS drug class prescriptions	$0.00
Total number of Prescriptions from Formulary	207,102
Percentage of prescriptions from Formulary vs. Total number of prescription filled	99.50%
Total Cost of **Trusted Health** Prescriptions	$10,537,905.15
HSCSN	
Total number of enrollees receiving prescriptions	4,475
Total number of prescriptions	71,680
Total number of prior authorization requests	1600
Total number of prior authorizations approved	1388
Total number of Hepatitis C drug class prescriptions filled by plan	0
Total amount paid for Hepatitis C drug class prescriptions	$0.00
Total number of HIV/AIDS drug class prescriptions filled by plan	0
Total amount paid for HIV/AIDS drug class prescriptions	$0.00
Total number of Prescriptions from Formulary	59,971
Percentage of prescriptions from Formulary vs. Total number of prescription filled	84.00%
Total Cost of HSCSN Prescriptions	$16,346,310.00
Grand Total for ALL Programs	**$289,388,354.15**
***PLEASE NOTE: The methodology for HIV prescription reimbursement to pharmacies was changed effective April 30,2016 due to the closing of the DOH Pharmaceutical Warehouse.**	
**Please note: Hepatitis C drug class is a new reporting category	
Drug Class-Information on Medicaid MCO prescriptions filled by therapeutic class, and by brand vs. generic is available upon request	

Alliance MCO	FY 2016
AmeriHealth Alliance	
Average number of Alliance members enrolled in plan per month	7,370
Average number of Medicaid members enrolled in plan per month	97,919
Total number of Alliance non-formulary prescriptions filled by plan	2092
Total amount PAID for Alliance non-formulary prescriptions filled by plan	$2,040,765.67
MedStar Alliance	
Average number of Alliance members enrolled in plan per month	4,210
Average number of Medicaid members enrolled in plan per month	46,789
Total number of Alliance non-formulary prescriptions filled by plan	599
Total amount PAID for Alliance non-formulary prescriptions filled by plan	$1,625,007.84
Trusted Alliance	
Average number of Alliance members enrolled in plan per month	3,763

Average number of Medicaid members enrolled in plan per month	30,499
Total number of Alliance non-formulary prescriptions filled by plan	47
Total amount PAID for Alliance non-formulary prescriptions filled by plan	$50,748.99
Total number of Alliance Hepatitis C drug class prescriptions filled by plan	9
Total amount paid for Alliance Hepatitis C drug class prescriptions	$168,073.35
Drug Class- Information on Alliance prescriptions filled by therapeutic class, and by brand vs. generic is available upon request.	
1. If an Alliance member needs to have a prescription filled for a non-formulary medication, the Alliance member must receive authorization from their health plan. Once authorized (authorization policies and procedures vary by MCO), the Alliance member can have the prescription filled by a pharmacy that is part of the MCO's provider network. The cost of these prescriptions is paid for and reported by the managed care plan in which the person is enrolled.	

Alliance	**FY 2016**
Total number of Alliance beneficiaries receiving non-formulary prescriptions	918
Total number of prescriptions (non-formulary)	2,747
Total Cost of all Alliance non-formulary Prescriptions	$3,884,595.85

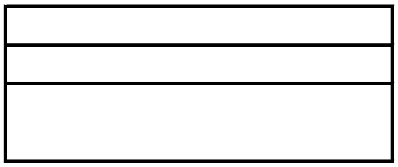
FY 2017
26,890
273,599
4,283
3,634
194
$5,913,859.00
N/A
N/A
19,011
$32,478,857.00
130,132
71.23%
$57,997,754.00
FY 2017
39,098
208,549
2,252
1,081
17
$428,836.82
0
$0.00
201,057
97.82%
$13,243,493.00
12,444
115,605
1,459
1,374
54
$1,645,659.80
0
$0.00
113,259
97.97%
$9,270,758.00
10,600
56,470
411

382
35
$676,600.14
0
$0.00
56,182
99.50%
$3,349,659.43
3,001
17,384
424
371
0
$0.00
0
$0.00
14,692
85.00%
$3,817,342.00
$87,679,006.43

FY 2017
7,115
96,917
1056
$646,712.63
4,699
50,204
452
$506,915.99
4,707

34,818
44
$44,303.07
0
$0.00

FY 2017
517
1,552
$1,197,931.69



DEPARTMENT OF HEALTH CARE FINANCE

Q50. Please provide the utilization rates for pharmaceuticals, broken down by:

a. Fiscal year (FY16 and to date FY17, if available);
b. Demographics;
c. Program (managed care, fee-for-service, or Alliance);
d. Total cost of prescriptions;
e. Utilization and costs for the DHCF Drug Warehouse.

Response:

The responses to Q50 (a) through (e) are presented in Attachment #1 to Q50.

Notes:

- Medicaid and Alliance data are separately reported for medications dispensed through fee-for service or by managed care plans.

- HIV medications were "carved out" from Managed Care plans into Medicaid Fee for Service (FFS) effective 01/01/2013. This change is reflected in the decreased drug spending in each managed care plan during FY16 and FY 17 to date and a corresponding increase for the FFS program during the same time frame.

- The Alliance program pharmacy benefit was transitioned to the member's respective managed care plan effective 06/01/2016 due to the closing of the DOH Pharmaceutical Warehouse. This change resulted in reported increased non-formulary Alliance drug spend by the managed care plans.

- The methodology for HIV prescription reimbursement to pharmacies was changed effective April 30, 2016 due to the closing of the DOH Pharmaceutical Warehouse. As of that date the District Medicaid program is no longer able to obtain significant discounts for the purchase of HIV antiretroviral and Alliance formulary medications.

- Hepatitis C drug data is a reporting category due to the significant impact of medication costs for this therapeutic class.

DEPARTMENT OF HEALTH CARE FINANCE

Q1. Please provide a current organizational chart for DHCF, and include:

a. The number of full time equivalents (FTEs) at each organizational level;
b. A list of all FY16 FTEs broken down by program and activity;
c. The employee responsible for the management of each program and activity; and
d. A narrative explanation of any organizational changes made during FY16 or to date in FY17.

Response:

Please see Attachment 1 to Q1 DHCF Response FY16 – Org Chart for the current organizational chart along with the number of full time equivalents (FTEs) at each organizational level.

Please see Attachment 2 to Q1 DHCF Response FY16 – FTEs at each organizational level, FTEs broken down by program and activity along with the employee responsible for the management of each program/activity.

DHCF received approval for an organizational change in its Long Term Care Administration (LTCA) on June 17, 2015. This organizational change was implemented in FY16, and in FY18, the LTCA's budget will be appropriately aligned with the change. The purpose of the change was to realign critical functions of the administration to better service the District's most vulnerable population and increase the effectiveness and efficiency of LTCA programs. The LTCA provides oversight and monitoring of programs targeted to elders, persons with physical disabilities, and persons with intellectual and developmental disabilities. Through program development and day-to-day operations, the LTCA ensures access to necessary, cost-effective, high quality extended and long-term care services for Medicaid beneficiaries residing in home and community-based or institutional settings.

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DEPARTMENT OF HEALTH CARE FINANCE

Q2. **For each vacancy posted during FY16 and to date in FY17, please state:**

a. The date that each position became vacant;
b. Why the position became vacant;
a. Steps that were taken to fill the position; and
b. The date the position was filled.

Response:

The Department of Health Care Finance (DHCF) posted a total of 37 vacant positions in FY16 and 7 vacant positions in FY17, to date. In FY16, positions were vacant due to competitive promotions, reassignments, resignations, terminations, retirements and additional approved FTE authority; in FY17, positions were vacant primarily due to promotions and resignations.

The goal of DHCF's recruitment process is to attract highly-qualified candidates that demonstrate the requisite knowledge, skills and abilities for each position. To recruit such highly qualified candidates, DHCF utilizes job fairs, an executive search firm, external entities and advertising on the professional organization websites, such as the National Association of Medicaid Directors and the Association of Certified Fraud Examiners.

Currently in FY17, DHCF has a 12% vacancy rate and has obtained approval to proceed with filling those vacancies.

Please see Attachment 1 to Q2 for FY16 and FY17 Vacancies.

DEPARTMENT OF HEALTH CARE FINANCE

Q4. **Please provide the amount budgeted and actually spent in FY16 and to date in FY17 for the agency and its programs and activities, broken out by source of funds, Comptroller Source, and Comptroller Object.**

Response:

Please see Attachment 1 to Q4 DHCF Response FY 2016. This report does not include Program Medicaid Provider Payments, which are captured in DHCF's Response to Question 24.

DEPARTMENT OF HEALTH CARE FINANCE

Q6. Please provide an update on all the cost-savings initiatives included in DHCF's FY17 budget, including projections of savings and their impact on Alliance and Medicaid populations.

Response:

Please see Attachment 1 to Q6 DHCF Response FY17.

DEPARTMENT OF HEALTH CARE FINANCE

Q14. Please provide the following information for all contracts awarded by DHCF during FY16 and to date in FY17, broken down by DHCF program and activity:

a. Contract number;
b. Approved Budget Authority;
c. Funding source;
d. Whether it was competitively bid or sole sourced;
e. Expenditures (including encumbrances and pre-encumbrances);
f. Name of the vendor;
g. Contract deliverables;
h. Contract outcomes;
i. Date of contract expiration after option years;
j. Any corrective actions taken or technical assistance provided;
k. DHCF employee/s responsible for overseeing the contract; and
l. Copy of the latest contractor performance evaluation.

Response:

Please see Attachment 1 to Q14 for responses to (a-f) and (i-k).
Please see Attachment 2 to Q14 for responses to (g-h).
Please see Attachment 3 to Q14 for responses to (l).

DEPARTMENT OF HEALTH CARE FINANCE

Q15. Please provide the following information for all contract modifications made during FY16 and to date in FY17:

a. Name of the vendor;
b. Purpose of the contract;
c. DHCF employee responsible for the contract;
d. Modification term;
e. Modification cost, including budgeted amount and actual spent;
f. Narrative explanation of the reason for the modification;
g. Funding source; and
h. Whether or not the contract was competitively bid.

Response:

Please refer to Attachment 1 to Q14 DHCF for responses to (a-c) and (g-h).
Please refer to Attachment 2 to Q14 for responses to (d-f).

DEPARTMENT OF HEALTH CARE FINANCE

Q16. Did DHCF meet the objectives set forth in the performance plan for FY16? For any performance indicators that were not met, please provide a narrative description of why they were not met and the corrective actions taken.

Response:

Please see the FY16 DHCF Performance Accountability Report in Attachment 1 to Q16.

DEPARTMENT OF HEALTH CARE FINANCE

Q17. What are DHCF's performance objectives for FY17?

Response:

Please see Attachment 1 to Q17 for DHCF's FY17 performance objectives.

DEPARTMENT OF HEALTH CARE FINANCE

Q24. For the Medicaid fee for service and managed care programs please provide the following for FY16 and FY17, to date:

a. Services provided and eligibility requirements, including a description of and reason for any change or planned change in FY16 or FY17;

b. Reimbursement rates/methodologies, including a description of and reason for any change or planned change in FY16 or FY17;

c. Enrollment and spending/costs, and utilization data, both current and projected, including statistical information by race, gender, ethnicity, and ward.

Response:

a. Eligibility:

To be eligible for the District of Columbia Medicaid Program you must:

- Be a resident of the District of Columbia
- Be a U.S. Citizen or have Qualified Immigration Status
- Must complete annual recertification
- Be eligible under the Modified Adjusted Gross Income (MAGI) Medicaid methodology or the Non-MAGI Medicaid methodology.
    - Have income at or below the income threshold established for the particular eligibility category
    - Meet a resource test for certain categories (i.e. Long Term Care)
    - Provide a valid SSN

MAGI group and income standards:

- Pregnant Women and Children (0-18) up to 319% FPL
- Children aged 19 and 20 up 216% FPL
- Parent/Caretaker Relative up to 216%FPL
- Former Foster Care (no income standards; FFS not assigned to an MCO)
- Childless Adults (21-65) up to 210% FPL

Non-MAGI based individuals include those who are:

- Age 65 or over, blind, or have a disability, with resources at or below $4,000 for a single person
- SSI recipients
- Long Term Care - Home and Community-based Waivers' participants
- Long Term Care - Individuals residing in an institutional setting
- Medicare Savings Program recipients
- Foster Care/Adoption Assistance
- Medically Needy Spend Down

- Under 19 years of age and qualify for TEFRA/Katie Beckett
- Have been screened and need treatment for Breast and Cervical Cancer

Benefits for the Medicaid FFS program are administered by DHCF. Benefits for the Medicaid Managed Care program, as indicated by the State Plan, are administered by the Managed Care Organizations (MCOs) contracted by DHCF.

Eligible Categories for the Managed Care Program:

- Children under age 21
- Parent/Caretaker Relatives
- Pregnant Women
- Childless Adults (21-65)
- 100% Locally Funded Programs in Managed Care
    - Immigrant Children Program
    - Alliance Program

The following tables (1 – 5) list the services provided and covered in accordance to the Medicaid Managed Care contract and Medicaid State Plan during FY16 and FY17.

Table 1: Covered Services for Managed Care Enrollees Ages 21 Years and Older

Service	FY16	FY17
Physician Services	√	√
Laboratory and X-ray Services	√	√
Inpatient Hospital Services (excluding services in an institution for mental diseases)	√	√
Outpatient Services	√	√
Prescription Medications	√	√
Emergency Services	√	√
Federally Qualified Health Center (FQHC) Services	√	√
Family Planning Services and Supplies	√	√
Pregnancy-Related Services	√	√
Nurse Midwife Services	√	√
Podiatry	√	√
Physical Therapy	√	√
Occupational Therapy	√	√
Prosthetic Devices	√	√
Vision Services (with limitations)	√	√
Home Health Services	√	√
Private Duty Nursing Services	√	√
Personal Care Services	√	√
Nursing Facility Services (excluding an institution for mental diseases)	√	√
Hospice Care	√	√

Transportation	√	√
Adult Wellness Services • Women's Wellness • Immunizations • Routine Screening for Sexually Transmitted Diseases • HIV/AIDS Screening, Testing and Counseling • Breast Cancer Screening • Prostate Cancer Screening • Screening for Obesity • Diabetes Screening • Screening for Hypertension and Lipid Disorders • Screening for Depression • Tobacco Cessation Counseling • Diet and Behavioral Counseling • Osteoporosis Screening in Post-Menopausal Women • Alcohol Misuse Screening and Behavioral Counseling • Aortic Aneurysm Screening	√	√
Dental Services (with limitations) • Adult Dental Crowns • Dental Implants	√ √ √	√ √ √
Hearing Services	√	√
Speech Therapy	√	√
Durable Medical Equipment (DME)	√	√

Table 2: Managed Care Covered Services for Children and Adolescents Through Age 20 Years

Service	FY16	FY17
All Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) • Screening and Assessment Services o Assessment of infant, child and adolescent health and development o Comprehensive health and developmental history (physical and mental); unclothed comprehensive exam; immunizations, laboratory tests including blood lead levels and health education with anticipatory guidance o Vision, Dental and Hearing Screening Services	√	√
Diagnostic and Treatment Services	√	√
All Medically Necessary Services	√	√
Fluoride Varnish by PCP (through 2 years)	√	√

Table 3: Managed Care Covered Mental Health Services

Services	FY16	FY17
Care Coordination and Case Management for behavioral health services provided by the Department of Behavioral Health	√	√
Inpatient Hospitalization and Emergency Department Services	√	√
Annual mental health and substance abuse screenings by the primary care physician (PCP)	√	√
Inpatient Psychiatric Facility Services for Enrollees through age 20 years	√	√
Pregnancy-related services, including treatment for any mental condition that can complicate the pregnancy	√	√
Patient Psychiatric Residential Treatment Facility (PRTF) Services for Enrollees < 22 Years	√	√
All mental health services included in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) during holidays, school vacations or sick days from school.	√	√

Table 4: Fee-For-Service Medicaid Covered Services

Service	FY16	FY17
Primary and Specialty Visits	√	√
Outpatient Services		
Physician Services	√	√
Preventive Care Services (including USPSTF A and B Recommendations)*	√	√
Emergency Services		
Family Planning Services and Supplies	√	√
Pregnancy-Related Services		
Nurse Midwife Services		
Prescription Medication	√	√
Hospitalization • General • Long-Term Acute • Rehabilitation • Psychiatric	√	√
Ambulatory Surgical Center	√	√
Medically Necessary Transportation	√	√
Dental Services and Related Treatment • Adult Dental Crowns • Dental Implants	√	√
Dialysis Services	√	√
Emergency Ambulance Services	√	√
Hospice Services	√	√
Laboratory Services	√	√

Radiology	√	√
Behavioral Health Services • Mental Health • Substance Use Disorder Services	√	√
Nurse Practitioner Services	√	√
Home and Community Based Services (HCBS)	√	√
Podiatry	√	√
Physical Therapy	√	√
Occupational Therapy	√	√
Prosthetic Devices	√	√
Vision Services (with limitations)	√	√
Hearing Services	√	√
Speech Therapy	√	√
Home Health Services	√	√
Private Duty Nursing Services		√
Personal Care Services		√
Nursing Facility Services (excluding an institution for mental disease)	√	√
Durable Medical Equipment (DME)	√	√
Transplants • Liver Transplantation • Heart Transplantation • Lung Transplantation • Kidney Transplantation • Allogeneic Stem Cell Transplantation • Autologous Hematopoietic Stem Cell Transplantation	√	√

* Preventive services recommended by the United States Preventive Services Task Force (USPSTF) – A full list of the services can be found at www.uspreventiveservicestaskforce.org.

The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications**.**

The Agency for Healthcare Research and Quality (AHRQ) has been authorized by the U.S. Congress to convene the Task Force and to provide ongoing scientific, administrative, and dissemination support to the Task Force.

Table 5: Alliance Covered Services

Service	FY16	FY17
Primary and Specialty Visits	√	√
Hospitalization	√	√
Laboratory Services	√	√

Pharmacy *(MCO scope of coverage effective July 1, 2016)*	√	√
Radiology	√	√
Routine Screening for STDs	√	√
Adult Immunizations	√	√
Women's Wellness • Pregnancy Care & Postpartum Services	√	√
Urgent Care Services	√	√
Dialysis Services	√	√
Screening and Stabilization of Emergency Medical Conditions	√	√
Prescription Medications	√	√
Pre-Authorized Home Health Services	√	√
Adult Dental (with limitations)	√	√
Emergency Transportation Services	√	√
PT, OT and Speech Therapy	√	√
Other • Family Planning Services/Supplies (Excluding Fertility Treatment) • HIV Screening, Testing and Counseling • Breast Cancer Screening • Prostate Cancer Screening • Screening for Obesity • Diabetes Screening • Screening for High Blood Pressure and Lipid Disorders • Screening for Depression • Tobacco Cessation Counseling • Diet and Behavioral Counseling • Osteoporosis Screening in Post-Menopausal Women • Alcohol Misuse Screening and Behavioral Counseling • Aortic Aneurysm Screening	√	√

Health Home 1 (My DC Health Home)

My DC Health Home began January 1, 2016. This program is a partnership between the DC Departments of Health Care Finance and Behavioral Health. A primary goal of the program is to improve the integration of physical and behavioral health of eligible beneficiaries. To be eligible for the program one must be diagnosed with a serious and persistent mental illness as identified by the DSM V.

My DC Health Homes are community-based mental health providers, also known as Core Services Agencies, which have hired nurses, primary care doctors and others with social and health-related backgrounds. These interdisciplinary teams will help coordinate a full array of health and social service needs—including primary and hospital health services; mental health care, substance abuse care and long-term care services and supports for both FFS and Managed Care beneficiaries

As of February 16, 2017 there are nine (9) My DC Health Homes providers and total of 1,477 beneficiaries are enrolled in the program. Of this number, 312 are enrolled in one of the three Manage Care Organizations (MCOs). The remaining 1,165 are Fee for Service beneficiaries. Eligible My DC Health Home providers are paid on a per member per month (PMPM) basis. There are two (2) sets of rates developed to reflect differences in the acuity levels; high acuity beneficiaries and low acuity beneficiaries. My DC Health Home providers are paid $481.00 for each high acuity beneficiary and $349.00 for each low acuity beneficiary enrolled in the program.

As of February 13, 2017, DHCF has reimbursed My DC Health Home providers approximately $3,310,609.00. Of this figure, $632,034 were paid for beneficiaries with a high acuity and, $2,678,575 were paid for beneficiaries with a low acuity.

During calendar year 2017, Quality Measures to include HEDIS standards will be compiled and analyzed to monitor the effectiveness of the program. Results from the evaluation of measures will be provided to both agencies and the MCOs.

Home Health II (My Health GPS)

In FY 2017, DHCF received approval from CMS to implement a second health home program, My Health GPS. My Health GPS is designed to provide enhanced coordination and integration of physical and behavioral health services for individuals with three (3) or more chronic conditions. As a part of My Health GPS, interdisciplinary teams embedded in the primary care setting will serve as the central point for integrating and coordinating the full array of eligible beneficiaries' (FFS and Managed Care) primary, acute, behavioral health, and long-term services and supports to reduce avoidable and preventable hospital admissions and ER visits and improve health outcome

Eligible My Health GPS providers will be paid on a per member per month (PMPM) basis. There are two (2) sets of rates developed to reflect differences in the acuity levels; high acuity beneficiaries and low acuity beneficiaries. My Health GPS Providers will be paid $137.40 for each high acuity beneficiary and $46.25 for low acuity beneficiary enrolled into the program. These rates reflect differences in the clinical staffing model and average expected service intensity for the two acuity levels. Notably, the District receives enhanced federal reimbursement of 90% for the first eight (8) quarters of the program. In the first quarter (July – Sept), My Health GPS providers can receive a one-time payment (per beneficiary) of $475.91 for beginning a care plan. These rates are effective with the implementation of the Health Home program on July 1, 2017.

Starting in FY19, a pay-for-performance (P4P) program will be implemented. My Health GPS providers will have a 10% withhold on their payments and will have an opportunity to earn back a portion or the entire withheld amount based on predetermined performance metrics.

b. Reimbursement/rate methodologies:

Managed Care Organizations (MCO)

The District contracts with Mercer Government Human Services Consulting (Mercer) to develop a risk-adjustment methodology that is applied to actuarially sound capitation rates for the MCOs. Risk-adjusted rates became effective beginning with the contract period of May 1, 2014 through the duration of each option year of the MCO contracts. The risk-adjustment results are re-evaluated every six (6) months, presently May and November. Any necessary updates will be applied as applicable throughout the contract period.

The risk-adjustment results are applied to average capitation rates for the District of Columbia Healthy Families Program (DCHFP). The DC Alliance (Alliance) program is not risk-adjusted at this time due to the following:

- The Alliance benefit package does not align with a standard Medicaid benefit package used in the nationally available risk-adjustment model; and
- The Alliance population has undergone significant change; the enrollment has declined.

Mercer also analyzes the MCO's reported encounter data using information provided by Conduent (formerly Xerox). Detailed information on the data analysis is captured in Data Books prepared for both the DCHFP and Alliance Program. The Data Books are shared and discussed with the MCOs during a series of meetings and discussions during the rate development process.

The rate ranges are prepared by Actuaries who are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid Managed Care capitation rates.

DHCF must receive approval from CMS on all updated or new capitation rates for the DCHFP prior to entry into the Medicaid Management Information System (MMIS) and paying to the MCOs. As of this writing, DHCF has not received approval on the updated certified MCO capitation rates that were to become effective on October 1, 2016. The MCOs are currently paid capitation rates that were approved by CMS for the period of May 1, 2016 through September 30, 2016

CMS does not review capitation rates developed for the Alliance program.

Effective July 1, 2016, DHCF incorporated the full Alliance pharmacy benefit, including some behavioral health medications, into the MCO's scope of coverage. This action was taken due to the inability of DHCF to obtain discounted pricing for Alliance medications through the Department of Health (DOH) Drug Warehouse. DHCF was notified that only 100% federally-funded programs are eligible for the discounted pricing. Alliance is a program that is solely funded through local dollars.

The updated benefit package for Alliance beneficiaries ensured continued access to their prescribed medications and additional pharmacies within their assigned MCO network.

The following charts include the reimbursement or capitation rates paid to each of the MCOs during FY16 and as of date in FY17. The current contract period ends on September 30, 2016, as well as the current capitation rates paid to the MCOs.

MCO Rates
(Effective 10/01/15 – 3/31/16)

Legacy Medicaid Population			
Rate Cohort	**AmeriHealth**	**MedStar**	**Trusted**
<1 Year, Male and Female	$488.41	$488.41	$488.41
1 – 12 Years, Male and Female	$203.47	$197.24	$184.35
13 – 18 Years, Female	$203.47	$197.24	$184.35
13 – 18 Years, Male	$203.47	$197.24	$184.35
19 – 36 Years, Female	$470.47	$463.56	$411.94
19 – 36 Years, Male	$470.47	$463.56	$411.94
37 – 49 Years, Female	$470.47	$463.56	$411.94
37 – 49 Years, Male	$470.47	$463.56	$411.94
50+ Years, Female	$470.47	$463.56	$411.94
50+ Years, Male	$470.47	$463.56	$411.94
Infant Month of Birth	$7,572.16	$7,572.16	$7,572.16
Mother's Month of Delivery	$8,863.45	$8,863.45	$8,863.45
775 Population			
19+ Years, Male and Female	$647.32	$593.45	$528.33

MCO Rates
(Effective 4/1/16 – Present)

Legacy Medicaid Population			
Rate Cohort	**AmeriHealth**	**MedStar**	**Trusted**
<1 Year, Male and Female	$488.41	$488.41	$488.41
1 – 12 Years, Male and Female	$202.21	$199.67	$188.32
13 – 18 Years, Female	$202.21	$199.67	$188.32
13 – 18 Years, Male	$202.21	$199.67	$188.32
19 – 36 Years, Female	$472.76	$464.48	$406.04
19 – 36 Years, Male	$472.76	$464.48	$406.04
37 – 49 Years, Female	$472.76	$464.48	$406.04
37 – 49 Years, Male	$472.76	$464.48	$406.04
50+ Years, Female	$472.76	$464.48	$406.04
50+ Years, Male	$472.76	$464.48	$406.04
Infant Month of Birth	$7,572.16	$7,572.16	$7,572.16
Mother's Month of Delivery	$8,863.45	$8,863.45	$8,863.45
775 Population			

19+ Years, Male and Female	$641.21	$605.01	$523.12

MCO Rates
(Effective 4/1/15 – 6/30/16)

Alliance Population			
19 – 36 Years, Female	$166.44	$166.44	$166.44
19 – 36 Years, Male	$132.61	$132.61	$132.61
37 – 49 Years, Female	$222.20	$222.20	$222.20
37 – 49 Years, Male	$196.72	$196.72	$196.72
50+ Years, Female	$394.06	$394.06	$394.06
50+ Years, Male	$431.37	$431.37	$431.37

MCO Rates
(Effective 7/1/16 – 9/30/16)

Alliance Population			
19 – 36 Years, Female	$185.69	$185.69	$185.69
19 – 36 Years, Male	$153.48	$153.48	$153.48
37 – 49 Years, Female	$276.18	$276.18	$276.18
37 – 49 Years, Male	$243.12	$243.12	$243.12
50+ Years, Female	$518.43	$518.43	$518.43
50+ Years, Male	$560.74	$560.74	$560.74

MCO Rates
(Effective 10/1/16 – Present)

Alliance Population			
19 – 36 Years, Female	$190.46	$190.46	$190.46
19 – 36 Years, Male	$152.53	$152.53	$152.53
37 – 49 Years, Female	$293.35	$293.35	$293.35
37 – 49 Years, Male	$250.05	$250.05	$250.05
50+ Years, Female	$648.50	$648.50	$648.50
50+ Years, Male	$660.84	$660.84	$660.84

c. Enrollment, spending, and utilization:

The enrollment data is included in Attachment 1 to Q24 DHCF Response - DHCF Enrollment FY16 and FY17 to-date.

Please refer to Attachment 1 to Q25 DHCF Response for FFS and MCO spending in FY16 and FY17, to date.

Please see Attachments 2 and 3 to Q24 DHCF Response - FFS and MCO Utilization, which includes utilization data (units of service) by provider-type for each of the Medicaid Fee-for-Service (FFS) and Managed Care programs for FY16 and FY17 to date.

Race, gender, ethnicity and Ward data is included in Attachment 4 to Q24 DHCF Response FY16 - AgeGenderEthnicityWard.

DEPARTMENT OF HEALTH CARE FINANCE

Q25. Please provide a service level breakout of expenditures for Activity Codes 5001 (Medicaid Provider Payments), 5002 (Medicaid Public Provider Payments), and 5003 (Alliance Provider Payments) for FY16 and to date in FY17.

Response:

Please see Attachment 1 to Q25.

DEPARTMENT OF HEALTH CARE FINANCE

Q29. Please provide an update on the status of each State Plan Amendment (SPA) identified as either planned or submitted to CMS in last year's oversight responses.

Response:

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY15	**1915(i) Adult Day Health Program**	Creates a new service under the Home and Community-Based Services (HCBS) Medicaid State Plan option that is designed to encourage older adults to live in the community by offering non-residential medical supports and supervised therapeutic activities in an integrated community setting, and by deterring more costly facility-based care.	Approved	Creates new day services designed for individuals with chronic illness who are over age 55.	None
FY15	**Transplantation Services**	Authorizes coverage for two new transplantation procedures – lung and autologous hematopoietic stem cell transplantations - while establishing provider participation standards.	Approved	Added lung transplants and autologous hematopoietic stem cell transplants.	None
FY15	**Pharmacy Supplemental Rebate Agreement**	Authorizes the District to enter into a new or renewal agreement with pharmaceutical manufacturers for outpatient drugs provided to Medicaid beneficiaries.	Approved	N/A	None

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY15	**Mental Health Rehabilitation Services for Children**	Adds a new section to the State Plan authorizing the delivery of evidenced-based mental health rehabilitation services for Medicaid eligible children.	Approved	Provides Medicaid reimbursement for two new services: Child-Parent Psychotherapy for Family Violence, and Trauma Focused Cognitive-Behavioral Therapy	None
FY15	**Specialty Hospital Payment Method**	Amends the State Plan to implement a prospective payment method for non-DRG hospitals.	Approved	N/A	None
FY15	**Inpatient Hospital Grouper & Payment Methods**	Amends the State Plan to update current DRG hospitals to a new grouper that will support better management of payment rates and refine the DRG payment method.	Approved	N/A	None
FY15	**Outpatient Hospital Payment Methods**	Amends the State Plan to support the new payment method for hospital outpatient services using Enhanced Ambulatory Patient Groups (EAPGs).	Approved	NA	None
FY15	**Subacute Services (Hospital)**	Creates a new level of inpatient mental health services for children.	Approved	New services for delivery in a Specialty Hospital setting	None

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY15	**Hospital Presumptive Eligibility**	Establishes a new ACA-required option for qualified hospitals to make a presumptive determination of an individual's eligibility to receive Medicaid services for a temporary "presumptive eligibility period" until permanent eligibility can be determined.	Approved	As required by the ACA, authorizes qualified hospitals to determine Medicaid eligibility based on preliminary information for a defined period.	None
FY15	**Nonpublic Schools**	Establishes a reimbursement methodology for delivering school-based health services in nonpublic school settings	Approved	Will add new school settings to delivering Medicaid reimbursable school based health services.	None
FY15	**Hospital Cost Report**	Aligns cost reports, auditing, records maintenance, administrative review, and appeals with the overhaul of the hospital payment methodology, including providing guidance for certain hospitals that will be paid transition rates in the first year of the methodology (or, for a new hospital, the first year the hospital enters the District).	Approved	No service changes	None

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY15	**Personal Care Services**	Makes technical corrections to the definition of scope of services allowable under State Plan Personal Care Aide (PCA) services to individuals with an institutional level of clinical need in accordance with sufficiency data analysis submitted by DHCF to CMS.	Approved	Clarifies definition of PCA services and adds cueing as a reimbursable service; changes assessment period to align with Medicaid recertification date; eliminates cap of 1040 hours, increases provider reimbursement rates and makes other clarifying changes.	None
FY15	**School-Based Health Services**	Amends the State Plan to delete Personal Care Service from the list of services delivered in a school setting	Approved	Removes Medicaid reimbursable personal care assistance services from the cost pool	None
FY16	**Primary Care Rate Increase Permanent Extension**	Amends the State Plan to permanently allow qualified primary care physicians to claim for certain services at 100% of the Medicare rate; additional extend this opportunity to Obstetricians and Gynecologists, Psychiatrists and Advanced Practice Registered Nurses	Approved	Extends the rate change permanently and the types of qualified practitioners eligible to claim the rate.	None

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY16	**Outpatient Hospital Supplemental Payments**	Continues the District's ability to provide supplemental payments to eligible District hospitals that participate in the Medicaid program through September 30, 2017.	Approved	No service changes	None
FY16	**Childless Adult Expansion 134 - 210% FPL**	Converts the District's prior Section 1115 waiver childless adult eligibility group for individuals aged 21-64 years with incomes from 134 – 210% FPL to a State Plan eligibility group. Making this change allowed the District to retain eligibility for this group without obtaining federal approval for a Section 1115 waiver demonstration program.	Approved	N/A (the District previously covered this eligibility group under a Section 1115 waiver)	None
FY16	**Reimbursement of Chemotherapy Drugs**	Authorizes the District to reimburse chemotherapy drugs that are administered on or after May 1, 2016 at one hundred percent (100%) of the Medicare fee schedule.	Approved	N/A	None
FY16	**Katie Beckett Cost-Effectiveness Methodology**	Establishes the cost-effectiveness methodology for the District Medicaid program to use in determining whether a child is eligible through the "Katie Beckett" eligibility pathway for children with an institutional level of care need for whom treatment at home is safe and more cost-effective than treatment in an institution.	Approved	N/A	None

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY16	**Private Duty Nursing Services**	Establishes eligibility criteria and provider requirements for private duty nursing, a more intensive skilled nursing service benefit offered under the State Plan home health benefit.	Submitted 9/30/16	Supplements existing guidance regarding eligibility criteria and provider requirements for private duty nursing services currently provided under the State Plan.	None
FY16	**Home Health Services (Skilled Nursing)**	Clarifies amount, duration, and scope of services offered under the State Plan home health benefit.	Submitted 9/30/16	Supplements existing guidance regarding provider requirements and service delivery parameters for home health services currently provided under the State Plan.	None
FY16	**Temporary Residency; State Residency for IV-E Foster Care Children**	Establishes parameters for enrollment in the District Medicaid program for otherwise eligible individuals who are District residents that are temporarily residing in another state. Includes guidelines for Medicaid coverage of Title IV-E foster care children placed in care outside of the District.	Approved	N/A	None

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY16	**Federally Qualified Health Center (FQHC) Reimbursement Methodology**	Establishes a new reimbursement methodology for FQHCs that participate in the District's Medicaid program, including updated prospective payment system (PPS) rates and procedures and a new set of four alternative payment methodology (APM) rates for primary medical care, behavioral health services, preventive and diagnostic dental, and comprehensive dental services. This SPA also establishes a new performance-based payment system which will require FQHCs to meet certain standards, provide quarterly reports, and assess performance based on three key measures, enabling FQHCs that qualify to receive additional performance-based payments annually, and beginning on January 1, 2018.	Submitted 8/22/16	Allows FQHC to bill on the same day for up to three service types for the same beneficiary (primary medical, behavioral and dental services). Also allows FQHCs to receive reimbursement for certain services provided through mobile units or in the home.	None

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY16	**Dental Services**	Clarifies criteria for dental services and limitations for adults and children. Identifies the criteria beneficiaries must satisfy in order to obtain prior authorization for the delivery of orthodontia services to child beneficiaries under twenty-one (21) years old and expands the provider types that can attest to the need for these orthodontia services. The SPA also corrects the description of service limitations for dentures, clarifying that coverage of dental prostheses is available to adult beneficiaries.	Approved	Corrects description of service limitations for dentures to clarify that District Medicaid provides coverage for both pediatric and adult beneficiaries.	None
FY17	**Youth Substance Abuse and Treatment Services** (formerly called the Adolescent Substance Abuse Treatment, or ASTEP)	Authorizes coverage of substance use disorder treatment delivered to Medicaid-enrolled youth under new Youth Substance Abuse and Treatment Services (YSATS) program (to replace current Adolescent Substance Abuse Treatment Expansion Program (ASTEP)). Replicates Adult Substance Abuse and Rehabilitative Services (ASARS), and would also be managed by DC Department of Behavioral Health (DBH).	Submit to Council by July 1 (pending review of draft)	The SPA clearly defines the substance use disorder (SUD) services available to vulnerable youth with SUD,	Not yet determined

Fiscal Year	SPA Name	Purpose	Status	Service Changes	Cost Savings
FY17	**Hospice**	Updates standards for the delivery of and reimbursement for adult hospice services, enabling DHCF to maintain compliance with new federal requirements regarding payment rates for routine home care services and increase monitoring and oversight of delivery of hospice services	Submit to Council by July 1 (currently making changes to draft pursuant to new data)	Provides additional guidance regarding the concurrent receipt of Personal Care Aide (PCA) services and services offered through the Home and Community-Based Services (HCBS) Waiver for the Elderly and Persons with Physical Disabilities (EPD Waiver) by beneficiaries who elect hospice.	None
N/A	**Disproportionate Share Hospital**	Amend the State Plan to redirect funds previously tied to the 1115 waiver to District hospitals.	Decision not to pursue	N/A	None

DEPARTMENT OF HEALTH CARE FINANCE

Q33: Please provide an update on the agency's plans to implement reimbursement for telehealth services, including:

a. The timeline for full implementation of the program including the dates of completion for any planned SPAs;
b. A description of potential reimbursement methodologies;
c. Any anticipated challenges or barriers to implementation;
d. Description of any concerns articulated by CMS, to date; and
e. A description of efforts to engage the community including a list of any planned meetings or conferences.

Response:

a. The timeline for full implementation of the program including the dates of completion for any planned SPAs:

DHCF determined through consultation with CMS that a SPA was not needed and that telemedicine reimbursement could be implemented through rulemaking. DHCF selected the rulemaking option, as it provided for quicker implementation. By selecting this option, CMS requires that DHCF reimburse for telemedicine services in the same way, and at the same amount, that they pay for face-to-face services/visits/consultations. After hosting numerous stakeholder meetings in 2015 and 2016, DHCF promulgated regulations to support reimbursement of telemedicine in 2016. The emergency and proposed rule was both adopted and deemed effective as of June 23, 2016. The rule was published on July 8, 2016. On the same date, DHCF issued Transmittal 16-21 which included a comprehensive guide for providers regarding the new telemedicine rule and billing instructions. DHCF is internally reviewing the public comments and will promulgate a second emergency and proposed rule in 2017. DHCF does not anticipate major changes to second emergency and proposed rule.

b. A description of potential reimbursement methodologies;

Effective June 23, 2016, eligible D.C. Medicaid providers may be reimbursed for approved services delivered via telemedicine at the same rate as in-person consultations. In order to remain consistent with the District's Medicaid reimbursement guidelines, additional reimbursement parameters were included for providers who are not reimbursed through the traditional fee-for-service process (e.g. FQHCs, Local Education Agencies, and Core Service Agencies) to prevent duplication of payment.

c. Any anticipated challenges or barriers to implementation;

DHCF has not experienced any major barriers to implementation. However, the utilization of the new telemedicine option for fee-for-service beneficiaries has been low. DHCF has observed a similar issue in other jurisdictions similar to the District because there has not been sufficient incentive for providers to change their practice patterns. Alternative payment models or modified fee-for-service payments offer the strongest incentives for telemedicine participation, especially for originating site providers. For that reason, there may be lower participation rates among providers operating in a traditional fee-for-service environment. DHCF will continue to monitor provider uptake of telemedicine services.

d. Description of any concerns articulated by CMS, to date;

CMS affords states a fair amount of flexibility around implementing Medicaid coverage for reimbursement of telemedicine services. DC has selected an option to implement telemedicine coverage/reimbursement without submitting a SPA. By selecting this option, CMS requires that DC reimburse for telemedicine services the same way/amount that they pay for face-to-face services/visits/consultations.

e. A description of efforts to engage the community including a list of any planned meetings or conferences.

DHCF has hosted four stakeholder meetings on the issue of telemedicine since 2014; one of which was held in 2016. The 2016 meeting outlined key aspects of the rule to solicit feedback prior to promulgation of the regulation. The meeting hosted 60+ stakeholders including representatives from DC Public Schools, DC Public Charter Schools, DC Primary Care Association, Department of Behavioral Health, DC Board of Medicine, City Council staff, Medicaid Managed Care Organizations, FQHCs, primary care providers, hospitals, and long-term care providers.

DEPARTMENT OF HEALTH CARE FINANCE

Q34: Please provide details regarding all Psychiatric Residential Treatment Facility (PRTF) placements paid for with Medicaid funds. To the fullest extent possible, please break down this data by what MCOs the youth were assigned to, length of time from Determination of Medical Necessity to youth's date of admission and placement at a Facility, reason for delays in admission and placement or rejections from facilities, the youth's length of stay, where the PRTF was located and what other District agencies were involved with each youth's case.

Response:

Background
The information presented below is based on prior authorizations for dates of service in FY16. It includes beneficiaries in Fee-for-Service Medicaid, as well as DHCF's current contracted Managed Care Organizations (MCOs), AmeriHealth, MedStar, Trusted Health Plan, and Health Services for Children with Special Needs (HSCSN).

Delivery Management Systems at Time of Placement
In both Fee-for-Service and Managed Care, Medicaid beneficiaries under the age of 21 needing a PRTF level of care have access to the PRTF benefit. After placement, however, the service delivery structure may change for individuals enrolled in one of the full-risk MCOs. Individuals enrolled in AmeriHealth DC, MedStar Family Choice, or Trusted Health Plan change from MCO enrollment to Fee-for-Service after approximately 30-59 days. At that time, monitoring of the level of care needs becomes the responsibility of the Department of Behavioral Health. Therefore, beneficiaries in FY16 that were receiving PRTF services under the Fee-for-Service structure may have been initially placed by an MCO. Beneficiaries enrolled in HSCSN remain in HSCSN, and beneficiaries initially enrolled in Fee-for-Service remain in Fee-for-Service.

Table 1 reflects an approximation of which delivery system (and, if managed care, which contractor) the beneficiary was enrolled with at the time of placement. There were a total of 80 Medicaid beneficiaries placed at a PRTF in FY16.

Table 1: Delivery Management System at Time of Initial Placement

Delivery Management System	Beneficiaries Served	Percent of Total
Fee-for-Service	35	44%
AmeriHealth Caritas DC	24	30%
MedStar Family Choice	4	5%
Trusted Health Plan	1	1%
Health Services for Children with Special Needs	16	20%
Total	**80**	**100%**

Length of Time from Determination to Placement
The letter of medical necessity issued by DBH is valid for 60 days from the date of determination; therefore the youth must be placed within that 60 day timeframe. Though the majority of youth that meet medical necessity are placed within that timeframe there are instances where they might be placed outside of the 60 days. Reasons for a delay in placement include:

- Youth has absconded
- Approval through the Interstate Compact on the Placement of Children (ICPC) is delayed
- PRTFs will not accept certain youth due to certain symptomatology.

Table 2 shows new placements in FY16 and excludes youth who were determined for a continued stay in the PRTF.

Table 2: Length of Time from Determination to Placement

	Length of Time from Determination to Placement
Range	13 – 126 days
Median	47 days
Average	55 days
Mode	33 days

Beneficiaries' Length of Stay
Each beneficiary's length of stay is highly dependent on the individual's diagnosis, condition, progress and prognosis. Therefore, the beneficiaries' length of stay varies greatly from beneficiary to beneficiary. Table 3 is based on the beneficiaries that were discharged at some point during FY 16; the youth that have not been discharged during this time are not included in this table.

Table 3: Youth's Length of Stay

	Length of Stay
Range	58 – 806 days
Median	220 days
Average	260 days
Mode	276 days

Table 4 outlines the states where the PRTFs are located and the number of beneficiaries served there.

Table 4: Beneficiaries Served by State

State	Beneficiaries Served
Alabama	3
Arkansas	12
Florida	10
Georgia	19
Indiana	4
Pennsylvania	1
South Carolina	1
Tennessee	4
Virginia	26

Sister Agency Involvement

The Department of Behavioral Health is responsible for certifying medical necessity for the PRTF level of care for placements to be funded by Fee-for-Service Medicaid. In June of FY11, a prior authorization requirement was put in place for PRTF care paid for by Fee-for-Service Medicaid. The prior authorizations are approved by DHCF only if medical necessity has been confirmed by the DBH PRTF Placement Review Committee. This committee also reviews and makes determinations about the need for continued stays in PRTFs.

If the youth was placed by a sister agency, the sister agency has primary responsibility to work with the PRTFs to ensure the appropriate reviews and authorizations are obtained. If the youth was placed by the family with the support of DBH, DBH takes the lead on oversight of the care being provided by the PRTF. DBH is actively working with other sister agencies to establish a centralized reporting and monitoring system for all current and future PRTF placements. DHCF continues to work with its contracted Managed Care Organizations and DBH to facilitate the smooth transfer of monitoring responsibilities for youth moving from Managed Care enrollment to Fee-for-Service Medicaid.

Table 5 is based on information from DBH and reports from HSCSN regarding which sister agency has placed the youth. If the youth is not affiliated with CFSA, DYRS, HSCSN, or CSS, DBH has primary responsibility for monitoring.

Table 5: Beneficiaries Placed at a PRTF by Sister Agencies

Agency	Number of Beneficiaries
CFSA	13
DCPS	2
DYRS	24
DBH	6
DC Superior Court	23
OSSE	2
HSCSN	10