DEPARTMENT OF HEALTH CARE FINANCE
FY20-21 OVERSIGHT QUESTIONS

A. General Budget and Organizational Questions

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 FY20 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 FY20 or to date in FY21.

Response:

a. Please see "Q1 Attachment 1" for the agency's current organizational chart, including the number of full-time equivalents (FTEs) at each organizational level.

b. Please see "Q1 Attachment 2" for FTEs broken down by program and activity.

c. Please see "Q1 Attachment 2" for the employee responsible for the management of each program and/or activity.

d. During FY20 and to date in FY21, there were no organizational changes.

Q2. Please provide the Committee with the following for FY20 and to date in FY21:

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 FY20 and to date in FY21 and the amount;
c. A list of travel expenses for FY20 and to date in FY21, arranged by employee; and
d. A list of all employees with a salary over $100,000.

Response:

a. Please see "Q2 Attachment 1" for a list of all employees who receive cell phones, personal digital assistants, or similar communication devices at agency expense.

b. Please see "Q2 Attachment 2" for a list of employees receiving bonuses, special pay, additional compensation, or hiring incentives in FY20 and to date in FY21 and the amount.

c. Please see "Q2 Attachment 3A" for a list of travel expenses for FY20, arranged by employee, and "Q2 Attachment 3B" for a list of travel expenses for to date in FY21, arranged by employee.

d. Please see "Q2 Attachment 4" for a list of all employees with a salary over $100,000.

Q3. Please identify any reprogrammings received by or transferred from DHCF during FY20 and to date in FY21 and include a description of the purpose of the transfer and which DHCF programs, activities, and services were affected.

Response:

Please see "Q3 Attachment 1" for reprogrammings received by and transferred from DHCF during FY20 and to date in FY21, including a description of the purpose of the transfer and which DHCF programs, activities, and services were affected.

Q4. Please identify any intra-district transfers received by or transferred from DHCF during FY20 and to date in FY21, and include description as to the purpose of the transfer and which DHCF programs, activities, and services were affected.

Response:

Please see "Q4 Attachment 1" for DHCFs Intra District Report.

Please note that the amount in the Received/Advanced Column on the attachment only reflects the status of the transfer of funds and does not reflect the intent of both agencies. Many of the MOU's are in process of being implemented by the agencies during FY21.

Q5. Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY20 and to date in FY21. 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 FY21 and to date in FY21; and
e. FY20 and to date FY21 expenditure of funds, including purpose of expenditure.

Response:

Please see "Q5 Attachment 1" for a complete accounting of DHCF's Special Purpose Revenue Funds for FY20 and to date in FY21.

Q6. Please provide the following information for all grants awarded to DHCF during FY20 and to date in FY21:

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

Response:

Please see "Q6 Attachment 1" for the information requested for all grants awarded to DHCF during FY20 and to date in FY21.

Q7. For each grant lapse that occurred in FY20, 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 FY21.

Response:

DHCF did not have any grant lapse in FY20. Please see "Q7 Attachment 1."

Q8. Please provide DHCF's capital budgets for FY20 and FY21 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 "Q8 Attachment 1" for DHCF's capital budgets for FY20 and FY21.

Q9. Please provide DHCF's fixed costs budget and actual dollars spent for FY20 and to date in FY21, 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:

a. Please see "Q9 Attachment 1" for DHCF's fixed cost budget and actual dollars spent for FY20 and to date in FY21, including source of funding.

b. DHCF's FY20 expenditures increased by $100,000 year over year due to increased energy and occupancy cost in FY20. The FY21 budget is approximately $777,000 lower as a result of a significantly reduced rent budget (L'Enfant Plaza space), offset by increases in the remaining fixed costs.

c. As a result of the ongoing pandemic, the agency anticipates lower utility costs as a result of prolonged remote working. DHCF is also working with DGS to ensure that location and cost for space allocation is accurate and up to date.

Q10. Please provide the following information for all contracts awarded by DHCF during FY20 and to date in FY21, broken down by DHCF program and activity:

a. Contract number;
b. Revised Budget Authority;
c. Funding source;
d. Whether it was competitively bid or sole sourced;
e. Expenditures (including encumbrances and pre-encumbrances); and
f. Name of the vendor.

Response:

Please see "Q10 and 11 Attachment 1" for information on DHCF contracts and contract modifications.

Q11. Please provide the following information for all contract modifications made during FY20 and to date in FY21:

a. Name of the vendor;
b. Purpose of the contract;
c. DHCF employee responsible for the contract;
d. Funding source; and
e. Whether or not the contract was competitively bid.

Response:

Please see "Q10 and 11 Attachment 1" for information on DHCF contracts and contract modifications.

Q12. Did DHCF meet the objectives set forth in the performance plan for FY20? 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:

All Key Performance Indicators (KPIs) with data currently available were met in FY20. Five KPIs are awaiting data. Please see "Q12 Attachment 1" for DHCF's FY20 Performance Accountability Report.

Q13. What are DHCF's performance objectives for FY21?

Response:

Please see "Q13 Attachment 1" for DHCF's FY21 Performance Plan.

Q14. Identify each District of Columbia agency that submitted Medicaid claims in FY20 and FY21, 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, including any pattern or common reason for the denial;
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:

a. Please see "Q14 Attachment 1" for the number total dollar amount of claims filed per agency each month.

b. Please see "Q14 Attachment 2" for the number and total dollar amount of claims denied per agency each month.

Based on FY20-21 denied claims history, the most common reasons for denials were:

- Exact duplicate claim;
- Ineligible program code;
- Beneficiary not eligible/not found;
- Beneficiary name mismatch;
- Service covered by MCO; and
- Diagnosis not valid for DOS.

c. The DC Fire and EMS Department (FEMS) is the only agency that uses a third-party billing agent, Zirmed.

d. The following agencies used the Administrative Services Organization (ASO) to handle their billing:

- DC Public Charter Schools;
- Office of the Status Superintendent;
- DC Public Schools; and
- Child and Family Services Agency.

At this time, there are no new opportunities for integration of other District agencies into ASO due to the following reasons: (1) procurement of their own billing vendor, (2) discontinuance of enrollment with DC Medicaid, or (3) no longer providing Medicaid reimbursable services. The remaining agencies—St. Elizabeth's Hospital and the Department of Behavioral Health (DBH)—turned to using billing agents within their agency. Specifically, DBH used billing agents within the agency for Mental Health Clinics (Note: In FY19, DBH discontinued billing for Mental Health

Rehabilitation Services (MHRS) and Substance Use Disorder (SUD) services. The individual provider agencies enrolled with DC Medicaid and began direct billing).

The Department of Youth Rehabilitation Services (DYRS) does not submit claims to Medicaid. The agency submits invoices from servicing facilities for ancillary services paid by the facility for fee-for-service eligible youth. DHCF reimburses the facility based on these invoices.

Q15. Please provide copies of any investigations, reviews, or program/fiscal audits completed on programs and activities within DHCF during FY20 and to date in FY21, including but not limited to reports of the DC Auditor, the Office of the Inspector General, Department of Health and Human Services OIG, and CMS. In addition, please provide a narrative explanation of steps taken to address any issues raised by the investigation, review, or program/fiscal audit.

Response:

1. ***CMS Payment Error Rate Measurement (PERM) program Cycle 3****:* The PERM program measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP) and produces error rates for each program. The Centers for Medicare & Medicaid Services (CMS) is required to estimate the amount of improper payments in Medicaid and CHIP annually. The program is operating under the PERM final regulation published on July 5, 2017. This cycle will review Medicaid and CHIP payments made in Reporting Year (RY) 2021 (July 1, 2019 through June 30, 2020). The RY 2021 improper payment rates are anticipated to be reported in the Agency Financial Report (AFR) published in November 2021. Additional details are available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Cycle_3.

2. ***CMS, Audits and Vulnerabilities Group, Division of State and Plan Program Integrity, Fiscal Year 2020 Compliance Plan Desk Review:*** This desk review is designed to assess compliance with the regulation outlined in 42 CFR 438.608(a)(1) related to the Managed Care Entity (MCE) compliance program/compliance plan. Requested documentation has been provided to CMS. Results will be provided when review complete (an estimated return date has not been provided).

3. ***States' Implementation of Medicaid Fee-For-Service (FFS) and Managed Care Organization (MCO) Provider Enrollment Requirements, evaluation conducted by the U.S. Department of Health and Human Services, Office of the Inspector General (OIG):*** The study was based on the requirements established by the Affordable Care Act and 21st Century Cures Act and covered various time frames from January 1, 2017 through January 1, 2019. The OIG objectives for the study were:
    a. To assess States' implementation of FFS and MCO provider enrollment requirements, and
    b. To provide Congress with information about the amount of Federal funds that States have received for Medicaid providers that are unenrolled.

    The evaluation report is available at: Twenty-Three States Reported Allowing Unenrolled Providers To Serve Medicaid Beneficiaries.

Q16. Please identify each incident of Medicaid abuse or fraud investigated in FY20 and to date in FY21 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'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 primarily 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 an investigation determines the case involves abuse. In addition, DPI oversees program integrity activities conducted by the District's Managed Care Organizations (including audits and investigations), conducts information sharing and coordination with the Department of Behavioral Health (DBH) and Department on Disability Services (DDS) concerning program integrity issues, and completes collaboration with law enforcement agencies.

DHCF investigated, or continues to investigate, 159 cases of alleged Medicaid fraud in FY20. In FY20, at least 15 cases were referred to law enforcement. As of December 31, 2020, DHCF investigated, or continues to investigate, 21 additional cases of alleged Medicaid fraud in FY21 (for a total of 180 cases investigated or continuing to be investigated across FY20 and FY21 to date). Please refer to Table 1 below for more detail on the investigative cases.

Based on preliminary investigations that are ongoing or have resulted in a credible allegation of fraud and a referral to law enforcement, problem areas include:

- Falsification of records/documents;
- Billing issues, including claims for services not rendered, excessive units of services, and other irregularities;
- Kickback payments or other illegal remunerations;
- Providing services without maintaining the necessary supporting documentation to justify the billing; and
- Organized groups involvement in fraud schemes, including the recruitment of beneficiaries and others into schemes.

Additionally, the collective program integrity efforts resulted in the discovery of the following problem areas or patterns:

- Personal Care Services, including Personal Care Aides and Participant Directed Workers related claims with excessive units of service billed, services not provided, and kickback payments;

- Community Service Workers related claims involving services not provided;
- Physician services fraud;
- Pharmacy claims involving prescription fraud, specifically billing for services not provided;
- Dental claims for services not provided and excessive units of service billed;
- Durable Medical Equipment and Prosthetics, Orthotics and Medical Supplies billings for excessive units, lack of documentation, and falsified documentation;
- Behavior health services' claims with excessive units of service and services not provided;
- Disability services claims with excessive units of service and services not provided;
- Providers billing for services reportedly provided to beneficiaries after the date of death;
- Providers submitting false information during Medicaid program enrollment process;
- Providers submitting claims for services during periods professional license was suspended; and
- Beneficiary involvement in fraud schemes, including falsification of medical conditions, falsification of records, and providing/accepting kickback payments or other illegal remuneration.

Normally, 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.

Table 1: Investigative Cases Details

Provider Type	Date Referred	Referred To	Status
Durable Medical Equipment	3/10/2020	Medicaid Fraud Control Unit & other Law Enforcement (MFCU & L.E.)	Pending Criminal Investigation
Mental Health Clinic Services	3/10/2020	MFCU & L.E.	Pending Criminal Investigation
Participant Directed Services	4/21/2020	MFCU & L.E.	Pending Criminal Investigation
Nursing Services	4/22/2020	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	4/22/2020	MFCU & L.E.	Pending Criminal Investigation
Participant Directed Services	4/22/2020	MFCU & L.E.	Pending Criminal Investigation
Participant Directed Services	4/22/2020	MFCU & L.E.	Pending Criminal Investigation
Dental Services	6/15/2020	MFCU & L.E.	Pending Criminal Investigation
DBH Services	9/18/2020	MFCU & L.E.	Pending Criminal Investigation
DBH Services	9/2/2020	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	9/28/2020	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	9/28/2020	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	10/08/2020	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	10/08/2020	MFCU & L.E.	Pending Criminal Investigation

Personal Care Services	11/5/2020	MFCU & L.E.	Pending Criminal Investigation
Beneficiary/Personal Care Services	--	--	Open Investigation
Beneficiary Abuse	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
DDS Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
DDS Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Beneficiary Fraud	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Beneficiary Fraud	--	--	Open Investigation
DDS Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Nursing Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
DDS Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Beneficiary Fraud	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Beneficiary/Personal Care Services	--	--	Open Investigation
DDS Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation

Participant Directed Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Home Health Agency	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Beneficiary	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Physician Services	--	--	Open Investigation
DDS Services	--	--	Open Investigation
Optometry Services	--	--	Open Investigation
Durable Medical Equipment	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Hospital Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Personal Care Services/Participant Directed Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Durable Medical Equipment	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services/Personal Care Services	--	--	Open Investigation
DDS Services	--	--	Open Investigation
Nursing Services	--	--	Open Investigation
Beneficiary Recruiter / Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Home Health Agency	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation

Pharmacy Services	--	--	Open Investigation
Transportation Services	--	--	Open Investigation
Home Health Agency	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Nursing Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Pharmacy Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Physician Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Beneficiary/Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Beneficiary/Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Home Health Agency	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Physician Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Mental Health Services	--	--	Open Investigation
Mental Health Services	--	--	Open Investigation
Physician Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Transportation Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
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Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Durable Medical Equipment	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Pharmacy Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Durable Medical Equipment	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Beneficiary	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
DBH Services	--	--	Open Investigation
DDS Provider	--	--	Open Investigation
Beneficiary	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
DDS Provider	--	--	Open Investigation

Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Dental Services	--	--	Open Investigation
Nursing Services	--	--	Open Investigation
Home Health Agency/Personal Care Services	--	--	Open Investigation
Personal Care Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Durable Medical Equipment	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation
Participant Directed Services	--	--	Open Investigation

Q17. For the Medicaid fee for service (FFS) and managed care programs, and the Alliance program, please provide a description of and reason for any changes or planned changes in FY20 and FY21, to date, regarding:

a. Services provided and eligibility requirements in FY20 or FY21; and
b. Reimbursement rates/methodologies in FY20 or FY21; and
c. Please explain, generally, how responses to (a) through (b) were impacted by the COVID-19 pandemic.

Response:

a. In FY20, the Office of Contracting and Procurement (OCP) issued a solicitation to contract with three managed care organizations (MCOs) to provide healthcare and pharmacy services for DHCF's Medicaid managed care program, also known as the DC Healthy Families Program (DCHFP). Through this solicitation, DHCF introduced a new category of eligible populations into the managed care scope of responsibility: adults with special health care needs, adults receiving Supplemental Security Income (SSI), and adults with SSI-related disabilities.

In FY21, DHCF transitioned approximately 17,000 Medicaid beneficiaries formerly enrolled in the fee-for-service (FFS) Medicaid program—identified as adults with special health care needs, adults receiving Supplemental Security Income (SSI), and adults with SSI-related disabilities—to the three newly awarded MCO contractors: AmeriHealth Caritas DC, CareFirst Community Health Plan, and Medstar Family Choice. Under the FFS program, these beneficiaries had to manage their health care needs without assistance or care coordination. By joining the DCHFP, these individuals will receive access to care coordination, and as a result, improved health outcomes.

Other FFS and managed care eligibility and service changes include:

- Pharmacy
    - In FY20, as part of the Section 1115 Behavioral Health Demonstration Waiver (1115 Waiver), DHCF removed the $1 copay for Medication Assisted Treatment (MAT) drugs.
    - In June 2020, DHCF implemented a process for pharmacists to administer vaccines, immunizations, and related emergency anaphylactic agents at the pharmacy point of sale for eligible FFS Medicaid beneficiaries.
    - In FY20, DHCF authorized in-network pharmacy providers to dispense a 72-hour (three day) emergency supply of medication(s) (determined by the pharmacist) while a prior authorization (PA) decision is being finalized for all Medicaid beneficiaries.
    - In FY20 and 21, DHCF added COVID vaccines and monoclonal antibody drugs and administration rates to the fee schedule. MCOs are to adhere to the DHCF fee schedule for administration reimbursement rates.

  - To improve access to Hepatitis C drugs, DHCF will eliminate the minimum fibrosis score requirement in FY21. This will allow equitable access for all Medicaid beneficiaries.
  - In FY21, DHCF is implementing a policy change that will carve-out coverage and reimbursement for medications approved for HIV pre-exposure prophylaxis (PrEP) and for HIV post-exposure prophylaxis (PEP) from the Medicaid managed care program. This will help address challenges with variable prior authorization requirements across the Medicaid program.
  - In FY21, DHCF is updating the acceptable Dispense As Written (DAW) Codes for pharmacy claims submitted at the point of sale (POS) for all Medicaid beneficiaries. This will reduce improper use of DAW codes.
- Medicine/Behavioral Health
  - Under the 1115 Waiver, DHCF allows Psychologists, Licensed Independent Clinical Social Workers (LICSWs), Licensed Professional Counselors (LPCs), and Licensed Marriage and Family Therapists (LMFTs) to bill for behavioral health services. Previously, only Psychiatrists could bill for behavioral health services.
- Dental
  - As of May 14, 2020, Medicaid enrolled dental providers are allowed to bill for oral health assessments rendered to beneficiaries using teledentistry.
  - Cone Beam Computed Tomography (CBCT) scan CDT codes are allowed for pre-surgical planning for dental implants and root canal re-treatment in FY20.
  - In March 2021, Quality Plan Administrators (QPA) will no longer serve as a Dental Benefit Provider for FFS Medicaid beneficiaries. The service will transition to the Quality Improvement Organization (QIO), Comagine.
  - Antigen and antibody testing for a public health-related pathogen Current Dental Terminology (CDT) codes were added to the fee schedule in 2021.
- Physical Therapy (PT), Occupational Therapy (OT), Speech and Language Pathology (SLP)
  - In FY20, DHCF increased the home health rate for PT, OT, and SLP. This in turn will allow the Medicaid FFS beneficiaries to receive these services in the home.
- Non-Emergency Medical Transportation (NEMT)
  - Protocols for NEMT services were updated in FY20 to comply with CDC and DC Health guidelines (e.g., Transportation providers and passengers required to wear masks during transport, vehicles not allowed to be scheduled to full capacity to allow for passenger spacing, use of hand sanitizers and disinfection of touch surfaces on vehicles).
  - In FY20, a Transportation Ombudsman position was added to the NEMT contract assist beneficiaries with navigating the NEMT system.
  - In FY21, non-emergency ambulance and bariatric vehicles were added to the NEMT contract for the FFS population.
  - In FY21, field monitors were added to NEMT contract to monitor pickup and delivery standards of transportation network provider's compliance with the NEMT contract.
- Child and Adolescent Supplemental Security Income Program (CASSIP)

- In FY21, the referral process for beneficiaries who request enrollment into the CASSIP (managed care program for children and adolescents with special health care needs) that did not meet the Social Security Administration (SSA) or the DC Economic Security Administration (ESA) medical and income eligibility criteria was discontinued.

b. The following changes were made to reimbursement rates and methodologies in FY20 and FY21 to date:

- ***MCO Directed Payment:*** Beginning in FY21 and effective with the new MCO contracts, DHCF implemented directed payment requirements for the MCOs that require them to reimburse providers at rates no less than the FFS payment rates for the following services:
  - Inpatient Hospital,
  - Outpatient Hospital,
  - FQHC, and
  - Primary Care.

  The purpose of the directed payments is to ensure reimbursement alignment and parity in rates between the MCO and FFS programs, and to reduce complexities surrounding the billing and claims payment process.

- ***FFS Changes:*** The reimbursement rates and methodologies for the Medicaid FFS program are described in the CMS approved Medicaid State Plan Amendment (SPA) for the District. SPA Section 4.19 – Payment for Services, is accessible at https://dhcf.dc.gov/node/192472.

  Generally, the reimbursement rates for each FFS category are adjusted annually/ periodically pursuant to the outlined reimbursement methodology in the SPA. The annual/periodic adjustments includes inflationary or cost changes as result of updates to the District's Living Wage rate that is published by the Department of Employment Services (DOES), the provider submitted cost report data, the Medicare market basket index, the Medicare Fee schedules updates, and/or other nationally recognized benchmarks for inflation or consumer price index.

In addition to the changes described above, other reimbursement rates/methodology changes made in FY20, and in or planned for FY21, under the FFS program are identified below:

- ***Outpatient Hospital Supplemental Payments:*** DHCF did not extend the outpatient hospital supplemental payment program for FY21. Prior to this change, in FY15 through FY20, DHCF annually received CMS approval to extend DHCF's authority to make supplemental payments to eligible hospitals for the provision of outpatient and emergency services to District Medicaid beneficiaries.

- ***Emergency Medical Transportation:*** Effective March 1, 2021, DHCF will update the interim rates reimbursed to FEMS. The interim rate updates are pursuant to the SPA cost-based reimbursement methodology and ensures the reimbursement closely reflects and aligns with the allowable costs incurred. The interim rate updates were determined from the audited financial data in the cost report and reported utilization for the covered emergency medical ground transportation services.

c. As a result of the COVID-19 public health emergency (PHE), broad policy decisions were taken to maintain current eligibility levels, provide enhanced reimbursement rates, and modify payment methodologies, and expanded coverage with reimbursement of telemedicine services.

In addition to the changes described in (a), the following additional service modifications were made due to the PHE:

- Telehealth
  - DHCF expanded standards governing Medicaid reimbursement of health services provided via telemedicine to allow the District to ensure the accessibility of services to Medicaid during the PHE.
- Pharmacy
  - During the PHE, DHCF authorized a 90-day supply of maintenance medications and a 30-day supply for non-maintenance medications.
  - During the PHE, DHCF allowed early refill for maintenance drugs at the beneficiary's request.
- Medicine/Behavioral Health
  - During the PHE, DHCF improved, encouraged, and increased access of telemedicine for all Medicaid beneficiaries.
- Hospitals
  - During the PHE, DHCF removed prior authorizations (PAs) for admissions and transfers to allow for easier access for FFS Medicaid beneficiaries to be admitted and transferred during a time of low bed availability.
- Tax Equity and Fiscal Responsibility Act (TEFRA)/Katie Beckett
  - During the PHE, DHCF allowed for automatic renewals; however, level of care documentation is still required.
- Out-of-State (OOS) Nursing Home
  - During the PHE, DHCF removed the PA requirement for OOS nursing home placement.

In addition to the changes described in (b), the following reimbursement rates/methodology changes were made in FY20 under the FFS program due to the PHE:

- ***COVID-19 PHE Rate Enhancements and Payment Method Changes:*** In FY20 and FY21 to date, DHCF implemented the payment of enhanced rates and changes to reimbursement methods for a subset of services. The rate and methodology changes

were an urgent response to the operational challenges, labor shortages, PPE costs, and financial hardship faced by providers during the PHE. Further, by implementing the changes, DHCF was able to stabilize and ensure continued access to critical health care services for District residents.

The enhanced rates and methodology changes are temporary and effective only during the pendency of the PHE. Specific services/provider groups where changes were made include:

- Personal Care Aides (PCA)/Home Health Agencies (HHA), including the Elderly and Persons with Physical Disabilities (EPD) Waiver;
- Skilled Nursing Services;
- Adult Day Health Program (ADHP), including the Elderly and Persons with Physical Disabilities (EPD) Waiver;
- Assisted Living Facilities;
- Nursing Facilities;
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID);
- Individuals with Intellectual and Developmental Disabilities (IDD) Waiver;
- Federally Qualified Health Centers (FQHC) Per Member Per Month (PMPM); and
- Adult Substance Abuse Rehabilitation Services (ASARS).

The transmittals notifying providers of the enhanced rates are available at: https://dhcf.dc.gov/page/2020-dhcf-medicaid-updates

- ***COVID-19 Laboratory Testing and Vaccine Administration Reimbursement:*** In FY20 and FY21 to date, DHCF approved coverage and reimbursement of COVID-19 testing and vaccine administration, adopting the billing codes and reimbursement rates utilized by Medicare. This approach helped to streamline and simplify the billing practices and mitigate any reimbursement rate disparity concerns during the PHE. The transmittals notifying providers of the enhanced rates are available at: https://dhcf.dc.gov/page/2020-dhcf-medicaid-updates

Q18. For the Medicaid and fee for service (FFS) and managed care programs, please provide enrollment and spending/costs, and utilization data, both current and projected, including statistical information by gender.

Response:

Please see "Q18 Attachment 1" for enrollment statistics by Fee for Service (FFS) and Managed Care Organization (MCO) populations. This information is also updated monthly and readily available on the DHCF website: https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports.[1]

Question 19 provides expenditure information related to the various programs under both FFS and MCO during FY20 and the first quarter of FY21. DHCF is currently in the process of reforecasting the FY21 anticipated expenditures for Provider Payments as a result of the changes due to the public health emergency and will have that available in the next Financial Review Process (FRP) submission (based on actuals through January 2021 and estimated from February through September).

[1] Due to a reprocurement of MCO contracts, Amerigroup was discontinued and MedStar was added as a plan as of FY2021. In addition, existing MCO beneficiaries were auto-assigned to new plans as of October 2020, with an option to select a different plan through December 2020.

Q19. 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 FY20 and to date in FY21.

Response:

Please see "Q19 Attachment 1" for a service level breakout of expenditures.

Q20. For each waiver program, please provide a description of and reason for any changes or planned changes in FY2020 and FY21, to date, and:

a. FY21Enrollment, spending/costs, and utilization data by service provided, and cost per enrollee, both current and projected, including statistical information by gender; and

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

Response

a. Please see "Q20 Attachment 1" for FY20 and FY21 to date enrollment by gender for the Elderly and Persons with Physical Disabilities (EPD) Waiver, and "Q20 Attachment 2" for FY20 and FY21 to date enrollment by gender for the Individuals with Intellectual and Development Disabilities (IDD) Waiver.

Please note that FY21 enrollment data should be considered preliminary. As with reports based on claims data, DHCF employs a three-month reporting lag for enrollment data to ensure accuracy and completeness of the data. DHCF posts updated enrollment reports, which include EPD and IDD Waiver enrollment, monthly on the DHCF website: https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports.

b. ***IDD Waiver***: The IDD waiver has a capacity of 1,883 for Waiver Year 3, (November 20, 2020 through November 19, 2021) and 1,903 for Waiver Year 4 (November 20, 2021 through November 19, 2022). As of January 31, 2021, 1,853 individuals were enrolled in the IDD Waiver. There is no waiting list.

In addition to the IDD Waiver, the District was approved for the Individual and Family Support Waiver (IFS) Waiver on November 1, 2020. The capacity for the IFS waiver is 30 for Waiver Year 1 (November 1, 2020 through October 31, 2021) and 60 for Waiver Year 2 (November 1, 2021 through October 31, 2022). This waiver has no enrollees as of January 31, 2021.

EPD Waiver: The enrollment cap for the number of unduplicated participants in Waiver Year 4 (April 4, 2020 through April 3, 2021) is 5,460; and for Waiver Year 5 (April 4, 2021 thru April 3, 2022) the capacity is 5,560. The enrollment is 4,767 as of January 31, 2021. There is no waiting list at present.

Q21. Please provide a list of all State Plan Amendments (SPAs) or demonstration projects submitted to CMS for approval in FY20 and FY21, or planned for submission in FY21 and FY21. 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.

Response:

Table 1, below, provides a description of all State Plan Amendments (SPAs) and demonstration projects submitted to the Centers for Medicare and Medicaid Services for approval in FY20 and FY21 to date. Table 2, below, provides a description of all planned SPAs for FY21.

Table 1: FY20 and FY21 SPA Submissions and Approvals (by February 22, 2021)

TN	SPA/Waiver	Description	Status	Service Change	Cost/Savings
19-002	Cost Based Reimbursement of Ambulances	Creates new FEMS supplement payment methodology.	Submitted: 6/29/2019 Approved: 12/16/2019 Effective: 4/1/2019	This amendment will allow the District to reimburse eligible governmental emergency ground transportation providers in accordance with the proposed cost-based methodology, effective April 1, 2019.	FY19 $975,000 FY20 $1,950,000
19-003	Physician Supplemental Payments	Provides supplemental payment to qualifying physician groups that deliver services in a hospital located in an underserved area.	Submitted: 9/18/2019 Approved: 12/4/2019 Effective: 11/23/2019	This amendment will allow the District to make supplemental payments in FY 2020 to Medicaid-enrolled physician group practices that contract with a public, general hospital located in an economically underserved area of the District to provide at least two of the following services: inpatient, emergency department, or intensive care physician services.	FY20 $3,150,000
19-004	Outpatient Supplemental	Proposes to extend availability of supplemental outpatient payment through FY19.	Submitted: 10/1/2019 Approved: 12/4/2019 Effective: 11/30/2019	The District's ability to provide supplemental payments to eligible District hospitals that participate in the Medicaid program.	FY20 $12,335,405 FY21 $12,335,405
19-005	Program of Inclusive Care for the Elderly (PACE)	PACE provides comprehensive medical and social services to certain frail, elderly people (participants) still living in the	Submitted: 10/1/2019 Approved: 2/3/2020 Effective: 2/11/2020	This amendment will authorize the District to implement a PACE program, effective February 1, 2020.	FY20 $1,652,322 FY21 $11,114,330

		community. Most of the participants who are in PACE are dually eligible for both Medicaid and Medicare.			
19-006	Recovery Audit Contractor (RAC) Increased Reimbursement	Makes technical changes to permit DHCF to increase reimbursement to RACs.	Submitted: 10/9/2019 Approved: 12/19/2019 Effective: 1/1/2020	This amendment will authorize the District to reimburse the Medicaid RACs up to the highest contingency Fee used under the Medicare RAC Program.	FY20 $0 FY21 $0
19-007	1915(i) Adult Day Health Program (ADHP)	Renews the District 1915(i) State Plan Adult Day Health Program.	Submitted: 12/3/2019 Approved: 3/18/2020 Effective: 4/1/2020	N/A	FY20 $4,481,029 FY21 $4,615,460
19-008	Adult Hospice	Codifies existing DHCF standards for the delivery and reimbursement of adult hospice services and updates policies to align with federal requirements regarding payment rates for routine home care services and increase monitoring and oversight of delivery of hospice services.	Submitted: 12/31/2019 Approved: 3/19/2020 Effective: 2/15/2020	This SPA updates the District's hospice care reimbursement methodology to align with federal requirements and enable the District to improve monitoring and oversight of the delivery of hospice services.	FY20 $4,842,839 FY21 $3,012,989
19-009	Pharmacist Administration Services	Proposes to authorize DHCF to reimburse pharmacists an administration fee for administering immunizations, vaccines, and anaphylaxis agents. Pharmacists would be able to directly administer these treatments for Medicaid beneficiaries.	Submitted: 12/31/2019 Approved: 2/19/2020 Effective: 2/19/2020	This SPA will permit the District of Columbia Medicaid program to reimburse pharmacists practicing within the scope of their licensure, for the administration of Medicaid-covered immunizations, vaccines, and emergency anaphylaxis agents, except for immunizations and vaccines covered under the Vaccines for Children program.	FY20 $0 FY21 $0
19-010	Home Health Reimbursement	The proposed amendment will permit the District of	Submitted: 12/31/2019 Approved:	N/A	FY20 $0 FY21

		Columbia Medicaid program to increase reimbursement rates for physical, occupational, and speech therapy services provided by a home health agency.	1/29/2020 Effective: 10/1/2020		$0
19-011	Drug Utilization Review Board and Pharmacy Lock-In	Proposes technical corrections to pharmacy lock-in language to better align with DHCF intent with regard to implementation; align with new requirements passed in federal SUPPORT Act.	Submitted: 12/31/2019 Approved: 3/23/2020 Effective: 10/1//2019	Restricts access to certain antipsychotic prescription medications for children, subject to review.	FY20 $0 FY21 $0
Section 1115 Waiver	Behavioral Health Transformation Demonstration	Enables the District's Medicaid program to pay for services provided to adults with serious mental illness (SMI) or substance use disorder (SUD) residing in an institution for mental disease (IMD). Additionally, the demonstration will add new community-based services designed to improve behavioral health treatment capacity and strengthen transitions from emergency, inpatient and residential treatment.	Submitted: 6/3/19 Approved: 11/6/19 Effective: 1/1/20	New services include: • Services for individuals aged 21-64 with SMI or SUD in an IMD setting; • Comprehensive Psychiatric Emergency Program Services • Youth Mobile Crisis • Adult Mobile Crisis and Behavioral Health Outreach • Psychiatric Residential Crisis Stabilization Services • Transition Planning • Services for individuals leaving a hospital, IMD or other facility • Recovery Support Services • Psychologist and Other - Licensed Behavioral Health Provider Services • Psychosocial Rehabilitative Services (also known as "Clubhouse" services) • Trauma Targeted Behavioral Health Services • Supported Employment Services, and	Demonstration Year 1 (1/1/20-12/31/20): $37,599,200 Demonstration Year 2 (1/1/21 – 12/31/21): $40,110,911

				• Eliminating the $1 copayment for prescriptions for medication assisted treatment (MAT)	
20-001	COVID-19 Emergency State Plan Amendment	Time-limited authority makes reimbursement and programmatic changes to state plan services in response to the COVID-19 public health emergency by increasing reimbursement rates to certain facility and home health providers; making substantive changes to the My Health GPS program; establishing delivery of Adult Day Health Program wellness checks via telemedicine; and other changes to the long term care services and supports assessment process to ensure continuity of services.	Submitted: 4/3/2020 Approved: 6/5/2020 Effective: 3/1/2020	Adjusts 1915(i) adult day health services, adjusts prescription drug day supply limits to allow and reimburse for dispensing of a 90-day supply of maintenance medications, waives physician authorization for LTCSS assessment and request for re-assessment, and modifies the My Health GPS health home program to eliminate acuity tiers, face-to-face requirements, and update care team staffing requirements.	FY20 Pending FY21 N/A
20-002	Personal Care Aide (PCA) Services Long Term Care Services and Supports (LTCSS) Assessment	Updates LTCSS assessment requirements for beneficiaries receiving PCA services, to align with changes made to the District's assessment process, EPD Waiver requirements, and corresponding regulations.	Submitted: 6/16/2020 Approved: 8/7/2020 Effective: 7/1/2020	N/A	FY20 $0 FY21 $0
20-003	COVID-19 Emergency SPA: Federally Qualified Health Center Reimbursement (FQHCR)	Time-limited authority establishes PMPM APM for FQHCs during period of the COVID-19 public health emergency.	Submitted: 6/25/2020 Approved: 8/6/2020 Effective: 3/1/2020	N/A	FY20 $11,376,762 FY21 N/A

20-004	1932(a) Managed Care Enrollment	Proposes SPA changes to support proposed transition of certain eligibility groups to managed care on a mandatory or voluntary basis and identifies eligibility groups that will be excluded from managed care or remain in fee-for-service.	Submitted: 7/1/2020 Approved: 8/10/2020 Effective: 10/1/2020	Authorizes the District to enroll approximately 17,000 District individuals, who are currently assessing their benefits via fee-for-service, into Medicaid managed care, effective October 1, 2020.	FY20 $0 FY21 ($16,170,000)
20-005	Reimbursement for Durable Medical Equipment Supplies, Prosthetics, Orthotics and Supplies (DMEPOS)	Revises DMEPOS requirements to conform to federal requirements to ensure beneficiaries can remain in community and expands scope of DMEPOS benefit to include medication management and personal emergency response system devices.	Submitted: 8/7/2020 Approved: 9/25/2020 Effective: 10/1/2020	Adds reimbursement for medical alert devices under state plan home health benefit.	FY20 $450,730 FY21 $555,660
20-006	COVID-19 Emergency SPA: 1915(i) Adult Day Health Program Retainer Payment	Time-limited authority establishes authority to pay retainer payments to 1915(i) Adult Day Health Program providers unable to provide services due to the public health emergency related to COVID-19.	Submitted: 9/1/2020 Approved: 9/25/2020 Effective: 3/11/2020	N/A	FY20 $224,291 FY21 $0

Table 2: SPAs Planned for FY 21

SPA/Waiver	Description
Burial Funds/Excess Resource Financial Eligibility	Proposes changes to the State Plan and DCMR to increase amount held in burial funds that is disregarded for purposes of financial eligibility. Additionally, proposes technical and substantive amendments to resource requirements set forth in Chapter 95 and 98 of Title 29 DCMR.
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) & Individuals with Intellectual and Developmental Disabilities (IDD) Waiver Supplemental Payment (Stevie Sellows)	Allows the District to make supplemental payments to ICF/IIDs and IDD waiver providers to provide for increased wages to support retention of Direct Support Workers using Stevie Sellows provider tax funds as the District match.

Beneficiary Sanctions	Proposes changes to expand DHCF's authority to sanction beneficiaries for participating in potentially fraudulent, abusive, or wasteful activities.
Certified Professional Midwives	Incorporates Certified Professional Midwife Amendment Act of 2020 by providing for the enrollment and reimbursement of licensed certified professional midwives.
Adult Day Health Program (ADHP) Rate Changes	Changes ADHP Tier 2 reimbursement rate to align with that of EPD Waiver ADHP.
ICP Eligibility	Amends legislation governing ICP and Chapter 73 to align eligibility requirements and application procedures with MAGI standard for Medicaid children.
MAGI Financial Eligibility	Amends eligibility requirements to reflect changes to MAGI-based income methodology to comply with federal legislative changes from the Tax Cuts and Jobs Act, the Bipartisan Budget Act of 2018, and the Healthy Kids Act (as outlined in the State Health Official [SHO] letter 19-003).
IDD 1915(c) Waiver Amendment	Amends IDD Waiver, adding self-direction option to multiple covered services.
RAC Waiver	Amends State Plan to request waiver of recovery and audit contractor requirements from CMS.
Housing Supportive Services (HSS)	Amends the State Plan to establish authority under section 1915(i) of the Social Security Act to reimburse for HSS services for beneficiaries who are or are at risk of homelessness.
Behavioral Health Provider Services/Other Licensed Providers	One of three SPAs that transitions community-based services now covered under Behavioral Health Transformation Waiver to coverage under the State Plan – this SPA will convert psychologist and other licensed behavioral health providers to State Plan authority.
Adult Substance Abuse Rehabilitative Service (ASARS)/Mental Health Rehabilitation Services (MHRS)	One of three SPAs that transitions community-based services now covered under Behavioral Health Transformation Waiver to coverage under the State Plan – this SPA will convert community-based mental health, SUD, crisis stabilization and transition services to State Plan authority.
Supported Employment Services (1915(i))	One of three SPAs that transitions community-based services now covered under Behavioral Health Transformation Waiver to coverage under the State Plan – this SPA will convert community-based supported employment services for individuals with serious mental illness and substance use disorder to State Plan authority under 1915(i) of the Social Security Act.
Living Organ Donor/Transplant	Adds Medicaid coverage of surgery, inpatient hospital, and other costs associated with transplant of liver and kidneys to Medicaid beneficiaries for living donors.
Physician Supplemental Payments	Provides a supplemental payment in FY 21 to eligibility physician group(s).
Outpatient Supplemental Payment	Sunsets Outpatient Supplemental payment effective 9/31/2020 in accordance with amendments made under the FY21 Budget Support Act.
Medication Assisted Treatment (MAT) for Opioid Use Disorders (OUD)	Amends the State Plan to identify the MAT for OUD services covered by the District Medicaid Program to provide CMS assurances that the District is in compliance with the requirements of section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.

Q22. 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, the youth's length of stay, where the PRTF was located and what other District agencies were involved with each youth's case.

a. **Please explain, generally, how the data provided in response to the questions above may have been impacted by the COVID-19 pandemic.**

Response:

Beneficiaries Served by PRTFs

Table 1, below, reflects which delivery system in which the PRTF beneficiary is served at the time of placement. Each Medicaid MCO is specified in the table below. There was a total of 23 Medicaid beneficiaries placed at a PRTF in FY20.

Table 1: PRTF Beneficiaries by Delivery Management System

Delivery Management System	Beneficiaries Served	Percent of Total
Fee-for-Service (FFS)	15	65.2%
AmeriHealth Caritas DC	5	21.7
Amerigroup	2	8.7%
Trusted Health Plan	1	4.4%
Continued Stay	(9)	0
Total	**23**	**100%**

Length of Time from Determination to Placement

The letter of medical necessity issued by the Department of Behavioral Health (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; or
- PRTF placement difficult due to symptomatology.

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. However, the average length of stay in a Psychiatric Residential Treatment Facility is six months (180 days).

Location of PRTFs

Table 2, below, outlines the states where the PRTFs are located and the number of beneficiaries served there.

Table 2: Beneficiaries Served by State

State	Beneficiaries Served
Arkansas	0
Florida	6
Georgia	6
Indiana	1
Pennsylvania	2
South Carolina	0
Virginia	8

Sister Agency Involvement

DBH is responsible for certifying medical necessity for the PRTF level of care for placements to be funded by FFS Medicaid. In June of FY11, a prior authorization requirement was put in place for PRTF care paid for by FFS 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 recommended for placement by a sister agency and approved by the Review Committee, the sister agency works with the PRTF to ensure the placement, appropriate reviews and authorizations are obtained, and works collaboratively with DBH for monitoring the care of the youth in the PRTF. DBH has primary responsibility for the oversight of the care being provided by all youths in PRTFs, including those placed by the family with the support of DBH. DBH actively works with sister agencies to establish a centralized reporting and monitoring system for all current and future PRTF placements. DHCF continues to work with its full-risk Medicaid MCOs (Amerigroup, AmeriHealth, and Trusted) and DBH to facilitate the smooth transfer of monitoring responsibilities for youth moving from Managed Care to FFS Medicaid in their placements. Please note that the District's special needs health plan, Health Services for Children with Special Needs (HSCSN), places and monitors their members in PRTFs.

Table 3, below, is based on information from DBH regarding which sister agency has placed the youth. If the youth is not affiliated with the Child and Family Services Agency (CFSA), the Department of Youth Rehabilitation Services (DYRS), or Court Social Services (CSS), DBH has primary responsibility for monitoring.

Table 3: Beneficiaries Placed at a PRTF by Sister Agencies

Agency	Number of Beneficiaries
CFSA	5
District of Columbia Public School (DCPS)	0
DYRS	0
DBH	12
DC Superior Court	6
Office of the State Superintendent of Education (OSSE)	0

a. There were no impacts to the information provided above as a result of the COVID-19 pandemic.

Q23. Please provide a status report on compliance with the terms and conditions set forth in the Salazar consent decree, specifically, changes made by DHCF to improve utilization of primary and dental care. Please explain whether this work has been impacted by the COVID-19 pandemic.

Response:

Salazar v. District of Columbia, Civil Action No. 93-452 (TSC), originally filed in 1993, is a long-running consent decree case governing several aspects of the District's administration of Medicaid, including: (1) service delivery of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit; (2) notice of the availability of the EPSDT benefit; (3) timely processing of initial applications for Medicaid eligibility; (4) adequate advance notice of termination from Medicaid benefits during annual renewal; and (5) reimbursement of eligible out-of-pocket expenditures. Provisions relating to the third category were dismissed by consent in 2009 after the parties agreed that the District had satisfied the exit criteria, and the provisions relating to the fourth category were dismissed by Court order in 2013 because those requirements conflicted with the Affordable Care Act (ACA). The single remaining claim involves service delivery of the EPSDT benefit to children enrolled in Medicaid. The case is aggressively litigated on an ongoing basis, resulting in numerous additional court orders that broaden the scope of required compliance by the Department of Health Care Finance.

On November 5, 2019, the District renewed its motion to terminate Court oversight, asserting that it has satisfied the conditions of the Settlement Order or, alternatively, that Court oversight is no longer appropriate given there is no ongoing legal violation. Briefing is stayed until further order of the Court.

In 2020, the District submitted all required reports to the Court. While the District consistently has met or was above the national average for utilization measures for well-child visits and dental services, utilization is below the target required by the 1999 Settlement Order and the 2003 Dental Order. Furthermore, the COVID-19 pandemic has negatively affected utilization measures nationally and in the District.

DHCF, through its own efforts and in working with MCOs, providers, and sister agencies, strives to increase utilization of preventive care and encourage families to take their children to the doctor for well-child visits. The national average for children ages 0-20 receiving well-child visits in FY19 was 60 percent, while the District reported a utilization rate of 63 percent. In addition, the District is above or close to the national average for all age categories specified in the CMS Form 416 (Annual EPSDT Participation Report). See Table 1 below for additional information by age.

Table 1: Well-Child Visits Among Children Ages 0-20

CMS 416 Data	District of Columbia FY19	National FY19
Overall Participant Ratio (ages 0-20)	63%	60%
Age Breakdowns		
Under 1	92%	92%
1-2	78%	81%
3-5	68%	71%
6-9	62%	56%

10-14	63%	56%
15-18	55%	47%
19-20	34%	25%

The District has historically ranked in the top tier of Medicaid programs nationwide in utilization measures, and the improvements in the District's dental benefit have been highlighted and commended by CMS. However, the expectations for utilization of dental services as outlined in the Dental Order remain problematic. The District continues to meet the substantive requirements of the Dental Order, but not performance measures, such as the requirement that 80 percent of Medicaid-enrolled children aged 3-20 years receive any dental visit. The latest data shows that the national average of any dental visit among Medicaid children aged 3-20 was 54 percent, while 64 percent of DC Medicaid children aged 3-20 years received any dental visit in FY19.

DHCF also continues to improve access to the pediatric dental benefit to encourage greater utilization. As required under the MCO contracts, all beneficiaries have a designated primary dental provider in addition to a primary care provider; this is intended to improve a beneficiary's ability to access dental services and strengthen the message that oral health care is connected to, and just as important as, primary medical care. Additionally, DHCF is enlisting the help of primary care providers to encourage parents to seek early oral health care for their children—and themselves—through changes in billing instructions and increased messaging to primary care providers about the importance of oral health through provider bulletins. Since payment for fluoride varnish applications was implemented in FY14, this is the fifth year DHCF was able to capture claims furnished by primary care providers for oral health services (fluoride varnish and oral health assessments) provided to children under age 3. The percentage of children under 3 years of age receiving fluoride varnish applications and/or oral health assessments during their well-child visit grew again in FY19 to 28 percent (from five percent in FY16).

As DHCF continues to work to improve utilization of primary and dental care, the agency remains proud of the District's progress and the efforts made to ensure access to medical care during the public health emergency.

Q24. What is the breakdown of funding sources for early intervention services provided through OSSE, including the percent covered by managed care organizations and the percent covered through fee-for-service?

Response:

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit constitutes the child health component of the Medicaid program. The benefit includes all health care services covered under federal Medicaid law necessary to identify, and then correct or ameliorate, any defects or chronic conditions found in beneficiaries under the age of 21.

Due to the broad scope of EPSDT, almost all Strong Start/Early Intervention Program (EIP) services, as defined under Part C of the Individuals with Disabilities Education Act (IDEA), also fall within the scope of the EPSDT benefit because such services are needed for the child's development. Table 1 below displays the expenditures for EIP services for both the managed care and FFS programs. Approximately 90 percent of children enrolled in DC Medicaid receive services through the managed care program, and 10 percent receive services through fee-for-service (FFS) arrangements.

Table 1: **Medicaid Expenditures for Early Intervention Program Services by Funding Source, FY20 and Q1 FY21**

	FY20		FY21 Q1	
Funding Source	**Payments**	**% of Total**	**Payments**	**% of Total**
FFS Claims	$84,572.08	2.1%	$0.00	0.0%
MCO Encounters	$3,860,566.07	97.9%	$606,991.33	100.0%
Total	**$3,945,138.15**	**100.0%**	**$606,991.33**	**100.0%**

Notes:

1. Data were extracted from the Medicaid Management Information System (MMIS) on March 1, 2021. MCO is managed care organization, which includes beneficiaries enrolled in Medicaid managed care and the Immigrant Children's Program.
2. Early Intervention Services were defined as procedures containing the modifier "TL" as directed in a February 26, 2018 DHCF transmittal to providers.
3. Analysis only included children 3 years old or younger on the date of service.

Q25. Please explain how the availability and accessibility of Medicaid managed care services and fee for service (FFS) services have changed during COVID-19 pandemic. Please include statistics on Medicaid service utilization (with breakdown by age, race, gender, ethnicity, and ward) during the pandemic (March 2020 to date) compared to pre-pandemic FY20 and FY19.

Response:

For information on the availability and accessibility of Medicaid services during the pandemic, please see response to question 17. For costs associated with the Medicaid program, please see responses to questions 18 and 19. For Medicaid enrollment and utilization data, please see "Q25 Attachment 1" and "Q25 Attachment 2," respectively.

Q26. How has enrollment and service utilization changed for children (0-20) in Medicaid FFS, Medicaid MCOs, and the Immigrant Children's Program during the COVID-19 pandemic?

Response:

Overall during the COVID-19 pandemic, enrollment has grown and service utilization experienced a sharp decline for children under age 21. Additional details are provided below:

Enrollment

The number of children enrolled in Medicaid increased by 5.5 percent, from 90,525 in February 2020 (prior to the public health emergency) to 95,728 in December 2020 (Figure 1). MCO enrollment of Medicaid children saw a steady increase month-to-month during the public health emergency (PHE), while by contrast, FFS enrollment of Medicaid children saw a sharp decline of 42.2 percent from February to December 2020 (Figure 2). This decrease in FFS enrollment is largely due to the continuous coverage requirement in effect during the PHE. Without this requirement, some children enrolled in MCOs would have lost coverage and then re-enrolled, having a brief period of FFS coverage before choosing or being assigned to an MCO. Thus, the number of children who are enrolled in FFS as a transition to or from managed care is lower, and the total FFS enrollment of children primarily reflects only children who were enrolled in FFS during the entire year.

Enrollment in the Immigrant Children's Program (ICP) was nearly flat during the PHE with a small decrease from 3,993 in February 2020 to 3,980 in December 2020 (Figure 1), or 0.3 percent decrease. This largely reflects the fact that the number of ICP beneficiaries aging out and transferring to Alliance coverage has exceeded the number of younger children newly enrolling in ICP coverage.

Figure 1: Percentage Change in Child Enrollment Since February 2020, by Program

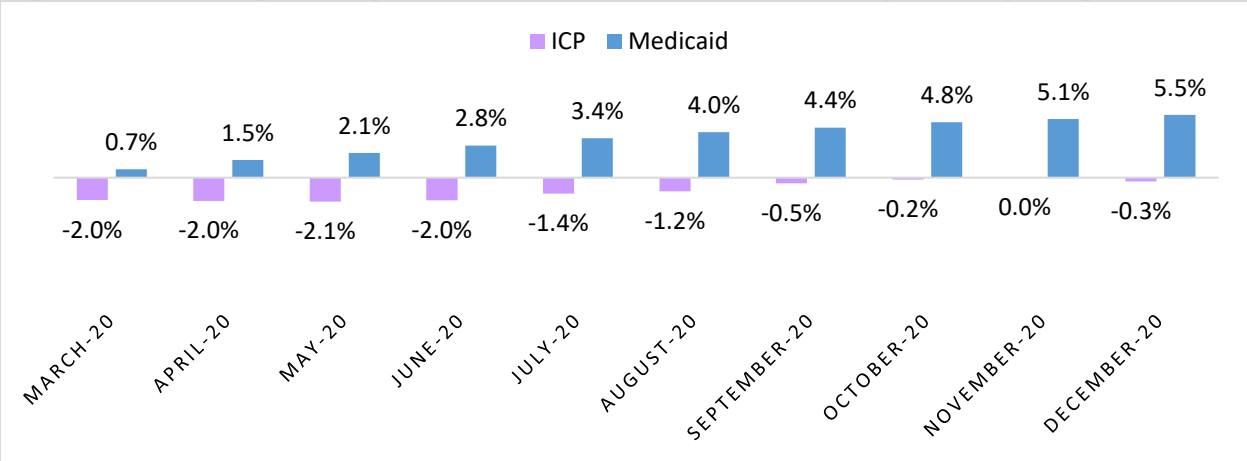
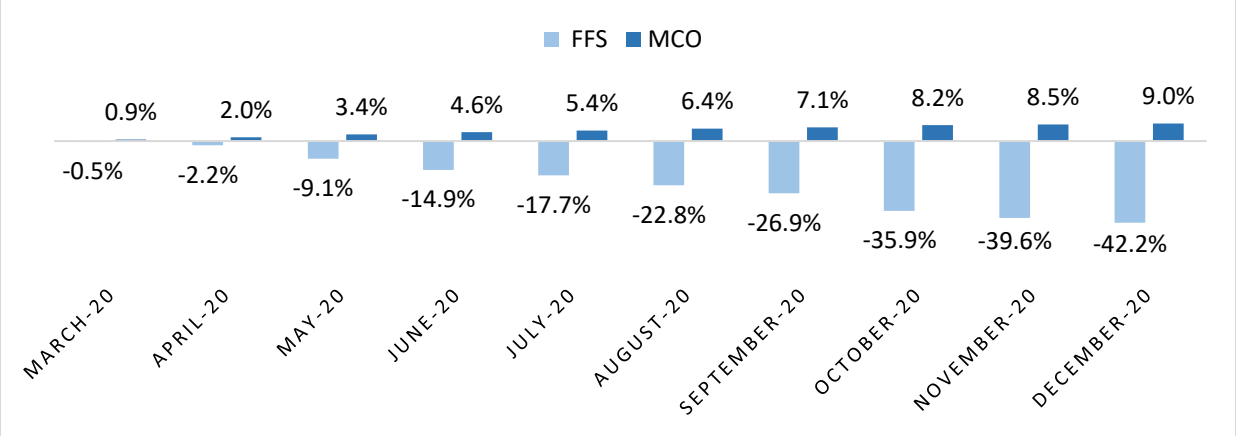


Figure 2: Percentage Change in Child Enrollment in Medicaid Since February 2020, by Service Delivery Type



Annual Well-Child Visit Utilization

After holding relatively steady or increasing in recent years, the District experienced a large drop in well-child visits in FY20, with preliminary data showing that the percentage of Medicaid children who received a well-child visit decreased by 21 percent, or 13 percentage points, from 63 percent in FY19 to 50 percent in FY20 (Table 1). As discussed in the next section, monthly data indicate that the decline coincides with the start of the COVID-19 pandemic.

Table 1: Percentage of Children with a Well-Child Visit, FY19 and FY20

	FY2019	FY2020[1]	Percentage Point Change	Percentage Change
Percentage of children with a well-child visit	63%	50%	-13%	-21%

[1] Claims data for FY2020 is still considered preliminary; DHCF will report its analysis of annual well-child utilization data to the Centers for Medicare & Medicaid Services by April 1, 2021.

Monthly Well-Child Visit Utilization

The District experienced a sharp drop in well-child utilization during March-May 2020 when compared to the same months in 2019, consistent with findings for other states.[2] The drops were not as substantial for June-September, but "catch up" visits to offset the drops seen in March-May also did not occur, leading to the overall FY20 decrease in well-child visits noted above.

On average during FY20, six percent of children enrolled in Medicaid received a well-child visit during any given month (Figure 3). The most substantial decrease in well-child visit utilization occurred during April and May of 2020, decreasing by 76 percent and 60 percent, respectively (Figure 4), compared to the same months in 2019. This represents a 5.7 and 4.7 percentage point decrease in the share of Medicaid children with a well-child visit in April and May, respectively, compared to the same months in 2019.

[2] https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot.pdf#page=13

Figure 3: Share of Medicaid Children with a Well-Child Visit by Month, FY20

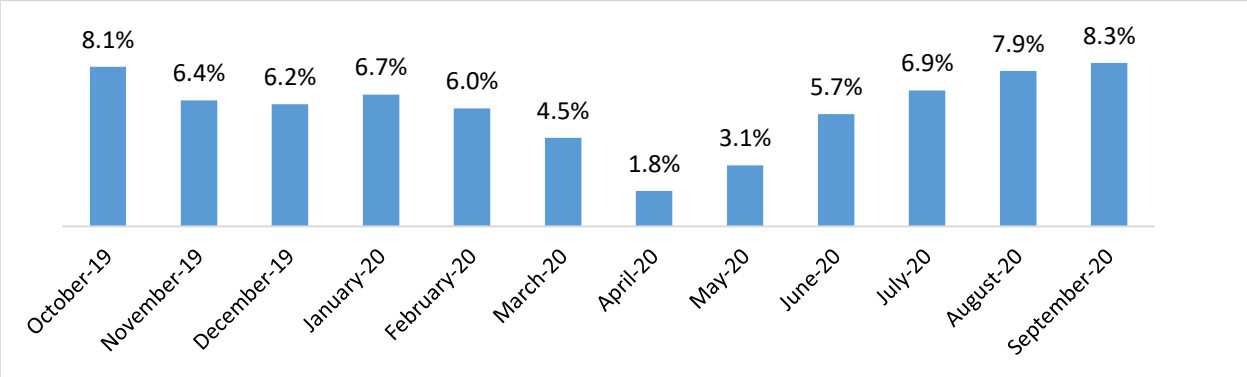
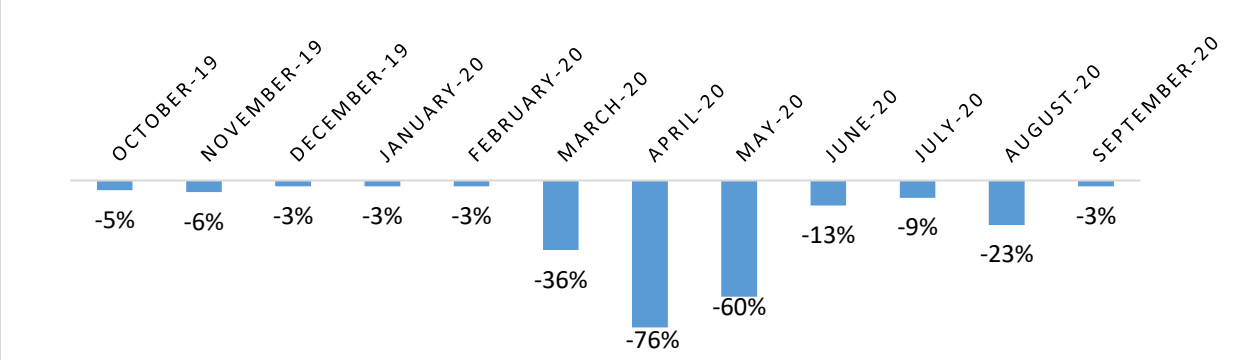


Figure 4: Percentage Change in Share of Medicaid Children with a Well-Child Visit, Compared to Same Month in Prior Year, FY20



Data Notes

- Eligibility and claims data were extracted from DHCF's Medicaid Management Information System on March 4, 2021.
- Complete data for annual well-child visit utilization for FY2019 for the District of Columbia can be found online in Form CMS-416 reports.[3] FY2020 data is not yet final.
- Well child visits are defined using the procedure codes and diagnosis codes listed in the Form CMS-416 instructions under Line 6.
- The annual utilization rates follow Form CMS-416 specifications and are restricted to children enrolled for at least 90 continuous days.
- The monthly well-child visit analysis is restricted to children enrolled in Medicaid at any point during the reporting month. Visit rates are calculated by dividing the number of children who received a well child visit in that month by the number of children enrolled during the month. This methodology differs from the CMS-416 and will produce rates that are lower and not comparable to the annual values.

[3] https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Q27. How is the DHCF assessing the quality and appropriateness of care furnished to MCO enrollees and FFS beneficiaries through telehealth?

Response:

The DHCF Division of Program Integrity (DPI) has conducted data analysis and claims reviews to identify trends, outliers, and abnormal billing patterns, including collaboration with other agencies and contractors responsible for administrating services. Based on the analysis and review, DHCF has provided additional guidance to providers on information that should be included in medical records, identified areas requiring additional utilization review, and initiated audits to confirm the appropriateness of billed services.

DHCF is also tracking telehealth utilization for outpatient services furnished to managed care enrollees and fee-for-service beneficiaries. Approximately 21 percent of all outpatient claims from April 2020 through September 2020 were for telehealth services and 32 percent of DHCF beneficiaries used at least one telehealth service. The most frequent type of outpatient services being offered via telehealth include behavioral health services.

DHCF continues to monitor the impact of telehealth on service delivery and changes to qualitative performance metrics. As more data becomes available, we will be able to discern any credible impact on quality metrics and will better be able to evaluate quality performance. DHCF will use the following mechanisms to assess the impact of telehealth on access to quality care for Medicaid beneficiaries:

- Each MCO is required to conduct Performance Improvement Projects (PIPs) that are designed to achieve, through ongoing measurements and interventions, significant improvement in clinical or non-clinical care areas expected to have a favorable effect on health outcomes. The MCO's PIPs must include measurements of performance using objective quality indicators, implementation and reporting of system interventions to achieve qualitative improvements, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement.

- As required by 42 CFR 438.330 and the District of Columbia Medicaid Managed Care contracts, each MCO must annually submit its Quality Assessment and Performance Improvement (QAPI) Program, which describes its systematic approach for assessing and improving the quality of care. The MCOs are required to submit an updated QAPI program description and evaluation annually.

- As part of DHCF's future review of MCO PIPs and QAPI evaluation, staff will review MCOs' interventions targeting use of telehealth services to assess access to quality services for enrollees.

- DHCF will review future impacts of telehealth services on quality metrics for DHCF's Federally Qualified Health Center (FQHC) pay-for-performance (P4P) program, which includes an assessment of adults' access to preventive care and care coordination metrics for attributed Medicaid beneficiaries.

Q28. Please provide a list of federal CARES Act funding received by DHCF related to the COVID-19 pandemic and indicate how the funding has been or will be spent.

Response:

The Department of Health Care Finance has not received any funding through the CARES Act during the public health emergency to date. DHCF has received $35 million in federal reimbursement from the FEMA Public Assistance Program funding to support the hospital surge grants awarded to 10 hospitals in the District. DHCF also has received 6.2 percent Enhanced Federal Medicaid Participation (EFMAP) from CMS beginning in January 2020 and currently estimated to continue through December 2021.

The EFMAP has been used in part to provide enhanced rates to providers during the pandemic, as well as support additional costs related to increased enrollment. The list of providers receiving enhanced rates is as follows:

Provider Type	Rate Adjustment
Nursing Facilities	20% enhanced rate
ICF/IID Facilities	15% enhanced rate
Assisted Living Facilities	20% enhanced rate
Federally Qualified Health Centers	Per Member Per Month rate
Home Health Agencies	Ability to bill for overtime and enhanced wage rate in specific cases
DD Waiver Providers	Retainer Payments, overtime, and enhanced wages
Adult Day Health Programs	Retainer Payment and adjusted per diem payment
Adult Substance Abuse Rehab (ASARS)	20% enhanced rate

Q29. When the pandemic is over, are there plans to extend telehealth authorities which have expanded throughout the public health emergency?

Response:

The comprehensive telehealth authorities DHCF has approved, which allow major categories of services to be delivered at a beneficiaries' home via telehealth so long as a licensed District Medicaid provider believes the service can be delivered at the standard of care, have been finalized. These policies are permanent and will therefore extend beyond the public health emergency (PHE).

During the PHE, DHCF has also granted temporary flexibility to deliver some long-term services and supports (LTSS) remotely to minimize risk associated with in-person services. However, many elements of LTSS delivery rely on or are enhanced by in-person interaction, such as face-to-face assessments, in-person case management, and/or in-person, community-based group services, such as those provided by our Adult Day Health Programs. As a result, DHCF expects most, if not all, elements of LTSS operations to return to the practices and procedures in place before the PHE.

One additional consideration is whether to continue the use of audio-only telehealth, which has been authorized during the PHE and can be extended via rulemaking once the PHE has ended. However, additional review of HIPAA compliance and clinical standards of care and quality are needed prior to making a final determination.

B. Medicaid/CHIP

Q30. How many children (under 18) in families who applied and were deemed eligible for Medicaid/CHIP in June 2018, June 2019, and June 2020 DC-wide and for each ward.

Response:

Table 1, below, displays the children enrolled in Medicaid in June 2018, June 2019, and June 2020 in each ward and DC-wide.

Table 1: Number of Children Under Age 18 Enrolled in Medicaid by Ward, June 2018-2020

Ward	June 2018	June 2019	June 2020
Ward 01	7,233	7,497	7,413
Ward 02	4,060	3,868	3,476
Ward 03	814	850	854
Ward 04	11,894	12,211	12,057
Ward 05	10,831	11,057	10,977
Ward 06	6,459	6,468	6,433
Ward 07	16,238	16,666	16,614
Ward 08	22,319	22,889	22,867
Unknown	2,826	2,840	2,539
Total Enrollment	**82,674**	**84,346**	**83,230**

Source: Data extracted from DHCF's Medicaid Management Information System on March 5, 2021.
Notes: The District does not have a separate CHIP program; instead, CHIP funding is used to finance Medicaid coverage for a subset of children. Unknown values for ward include cases where a mapping of the beneficiary's address is not readily available (e.g., due to a non-standard address format).

Q31. What percentage of children enrolled in Medicaid have a medical provider by through a Managed Care Organization? What percentage of children enrolled in CHIP/Healthy Families have a medical home?

Response

DHCF reports annually on enrollment and utilization numbers for children aged 0-20 receiving the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit, the child health component of the Medicaid program, to CMS on Form CMS-416. In the most recent reporting year, FY19, 96,732 children aged 0-20 were enrolled for 90 continuous days or more, and of those children, 91 percent (88,379) were enrolled in managed care arrangements. All children enrolled in managed care are assigned to a primary care provider.

DHCF requires MCOs to report standard quality measures, including Healthcare Effectiveness Data and Information Set (HEDIS) measures, which consist of evidence-based process and outcome measures related to clinical care. As part of their annual HEDIS quality measurement reporting, DHCF requires MCOs to report on children and adolescents' access to primary care practitioners (PCP). For the most recent audited measurement year, calendar year 2019, the MCO weighted averages for the percentage of enrollees12 months to 19 years of age who had a visit with a PCP are listed in Table 1 below.

Table 1: Percentage of Enrollees 12 Months to 19 Years of Age with a Visit with a PCP

Age	Share with a PCP Visit
12 to 24 months	92.28%
25 months to 6 years	81.23%
7 to 11years	89.99%
12 to 19 years	89.47%

Note: Certain continuous enrollment requirements apply to determine the eligible population for this measure. Enrollees 12–24 months and 25 months–6 years of age, must be continuously enrolled during the measurement year. Enrollees 7–11 years and 12–19 years of age must be continuously enrolled during the measurement year and the year prior to the measurement year. Enrollees may not have greater than one-month gap in coverage to be considered continuously enrolled.

Q32. What percentage of children enrolled in Medicaid have been seen by a physician at their primary physician by Managed Care Organization? What percentage of children enrolled in CHIP/Healthy Families have been seen by a physician at their primary physician?

Response:

DHCF is assuming that the request is for information on all children enrolled in Medicaid (including CHIP/Healthy Families) who saw a physician as their primary care source, with a specific breakout by managed care organization. Please see question 31 for information on children enrolled with a visit to a primary care practitioner.

In FY20, 50,148 children under age 21 enrolled in Medicaid saw a physician for at least one ambulatory care visit (i.e., had a physician as their rendering provider for an outpatient care visit). There were 62,864 children enrolled in Medicaid who had at least one ambulatory care visit where the rendering provider type was known. Based on these figures, 80 percent of children enrolled in Medicaid with a known provider type for ambulatory care were seen by a physician. The table below presents the number of children who saw a physician by MCO and FFS coverage.

Table 1: Children Enrolled in Medicaid/CHIP/Healthy Families Who Saw a Physician for At Least One Ambulatory Care Visit, FY20

FFS or MCO Enrollment	Children who saw a physician	Children who saw any known provider type	Share of children who saw a physician as a percentage of children who saw any known provider type
MCO Total	**48,049**	**60,000**	**80%**
- Amerigroup	6,213	10,277	60%
- AmeriHealth	32,470	38,480	84%
- CareFirst	6,217	7,690	81%
- HSCSN	3,149	3,553	89%
Fee-for-Service	**2,099**	**2,864**	**73%**
Total	**50,148**	**62,864**	**80%**

Source: DHCF Medicaid Management Information System (MMIS) data as of March 8, 2021.
Notes: Children are defined as under age 21 on the date of service. MCO and FFS status reflects a child's most recent month of enrollment. Analysis reflects managed care organization encounters and fee-for-service claims and is restricted to paid, final records with dates of service in FY2020. Physicians are defined as practitioners who have a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) provider type. Codes from the ambulatory visits 2020 HEDIS value set were used to identify visits. Due to the fact that not all managed care encounters include a rendering provider type, most notably in cases where the billing provider is not enrolled with DHCF's fee-for-service program, the number and percentage of children seen by a physician is likely an undercount. In addition, many children had ambulatory visits with a hospital or federally qualified health center (FQHC) listed as the rendering provider. It is not known whether the services rendered during these visits were by a physician but it is likely that some were, which would lead to an undercount in the data presented in this table.

Q33. Please describe where health care access and service has improved during the pandemic for people enrolled in Medicaid or Healthy Families (e.g. tele-health as an option for more services)? Of those, which do you plan to continue post-pandemic?

Response:

The comprehensive telehealth authorities DHCF has approved, which allow major categories of services to be delivered at a beneficiaries' home via telehealth so long as a licensed District Medicaid provider believes the service can be delivered at the standard of care, have been finalized. These policies are permanent and will therefore extend beyond the public health emergency (PHE). DHCF implemented these changes at the beginning of the PHE in mid-March. In response, Medicaid providers were able to rapidly pivot and deliver needed services using telehealth, preserving access to care and minimizing risks associated with in-person services during the pandemic.

In January and February 2020, telehealth accounted for just 0.3 percent of outpatient claims and only 0.8 percent of beneficiaries had a telehealth service. By comparison, in April and May 2020, telehealth claims accounted for 21.7 percent and 19.5 percent, respectively. Approximately 21 percent of all outpatient claims during April 2020 through September 2020 were for telehealth services and 32 percent of DHCF beneficiaries used at least one telehealth service.

See the response to question 29 for more information.

C. D.C. Healthcare Alliance

Q34. For the Alliance program, please provide data on the percentage of terminations each year since requirement has been in place.

Response:

In October 2011, DHCF implemented the six-month, face-to-face recertification process for DC Healthcare Alliance Program ("the Alliance") enrollees.[4] The intention of the six-month, face-to-face recertification requirement was to increase accountability for District residency and deter non-resident enrollment. Since this requirement was implemented, the annual percentage of Alliance beneficiaries who did not re-enroll within one year and therefore exited the program has ranged from a high of 29 percent in the first year of implementation (FY12) to a low of one percent in FY21 due to continuity of coverage requirements for the COVID public health emergency (PHE). During the PHE, which began in March 2020, Alliance enrollees automatically had their coverage extended and their coverage could only be terminated if they were no longer residents of the District of Columbia, requested an end to their coverage, or were deceased. Because of this automatic extension, the number of Alliance enrollees who had their coverage terminated in FY20 and FY21 was significantly lower compared to prior years.

The table below provides the number of beneficiaries who were enrolled each Fiscal Year between 2012 and 2021 to date, the total number of terminations in each of those fiscal years, and the percentage of individuals who were terminated who did not either transition to Medicaid or re-enroll in the Alliance program out of the total enrollment that year, without specifying the reason for termination (i.e., lack of engagement in the recertification process, or loss of eligibility due to income or citizenship).

Table 1: DC Alliance Enrollment Analysis, FY 2012-FY 2021 YTD

Fiscal Year	Total Alliance Beneficiaries Ever Enrolled	Total Terminated	Total Terminated and Re-enrolled in Alliance Within 1 Year	Total Terminated and Re-enrolled in Medicaid Within 1 Year	Net Terminated and Not Re-Enrolled in Medicaid or Alliance Within 1 Year (% of Total Enrollment)
2012	29,108	12,736	3,675	598	8,463 (29%)
2013	21,957	8,412	3,168	316	4,928 (22%)
2014	21,109	7,225	2,830	250	4,145 (20%)
2015	21,920	7,688	2,981	277	4,430 (20%)
2016	22,021	7,955	2,821	351	4,783 (22%)
2017	22,183	7,743	2,906	181	4,656 (21%)
2018	21,467	7,765	3,014	148	4,603 (21%)
2019	21,162	7,318	2,880	135	4,303 (20%)

[4] For the purposes of this response, DHCF is assuming the reference to "requirement" is the six-month recertification requirement.

2020	20,309	3,328	909	56	2,363 (12%)
2021 YTD	19,242	110	3	0	107 (1%)

Source: DHCF Medicaid Management Information System (MMIS) data extracted February 18, 2021.
Notes: Beneficiaries who disenrolled from the Alliance program, but immediately enrolled in the Medicaid program were not included in the count of terminated beneficiaries. The number of Alliance enrollees who had their coverage terminated in FY 2020 and FY 2021 was significantly lower compared to prior years because coverage was automatically extended to enrollees during the public health emergency.

Q35. For the Alliance program in FY20 and FY21, please provide the following data:

- **a. The total number of DC HealthCare Alliance enrollees required to recertify.**
- **b. The number of DC HealthCare Alliance enrollees required to re-certify who successfully completed recertification.**
- **c. The number of DC HealthCare Alliance enrollees required to re-certify who did not successfully complete re-certification.**
- **d. The number of DC HealthCare Alliance enrollees described in (c) who re-enrolled in Alliance within:**
  - **30 days of termination**
  - **Between 31 and 60 days of termination**

Response:

The table below illustrates the Alliance program recertification data requested above. Due to the public health emergency, Alliance enrollees had their coverage automatically extended starting in March 2020, and there have been no Alliance enrollees required to recertify to maintain eligibility since that time. We report "0" monthly Alliance enrollees with a recertification date in the month beginning in March 2020.

During the first five months of FY20 (October 2019 through February 2020), there was an average of 2,052 Alliance beneficiaries who had a recertification date in any month during that five-month period. Of the Alliance beneficiaries with a recertification date during a given month, about 70 percent were enrolled in the following month (i.e., continuously enrolled or re-enrolled within 30 days) and an additional three percent were enrolled as of the second month after their recertification date (i.e., re-enrolled between 31-60 days). Most of these beneficiaries re-enrolled in Alliance. There were small numbers of Alliance beneficiaries that recertified each month (typically less than 20 individuals) who transitioned to Medicaid.

Table 1: Monthly Alliance Recertification Data, FY 2020 and FY 2021 YTD

Month	Number of Alliance enrollees with a recertification date in the month	Number who recertified*	Number who did not recertify**		
			Total	Number who re-enrolled within 31-60 days	Number who did not re-enroll or re-enrolled after more than 60 days
Oct-19	1,951	1,320 (68%)	631 (32%)	60 (3%)	571 (29%)
Nov-19	1,954	1,305 (67%)	649 (33%)	77 (4%)	572 (29%)
Dec-19	2,137	1,471 (69%)	666 (31%)	77 (4%)	589 (28%)
Jan-20	2,259	1,759 (78%)	500 (22%)	47 (2%)	453 (20%)
Feb-20	1,963	1,328 (68%)	635 (32%)	36 (2%)	599 (31%)
Mar-20	0	N/A	N/A	N/A	N/A
Apr-20	0	N/A	N/A	N/A	N/A
May-20	0	N/A	N/A	N/A	N/A
Jun-20	0	N/A	N/A	N/A	N/A
Jul-20	0	N/A	N/A	N/A	N/A

Month	Number of Alliance enrollees with a recertification date in the month	Number who recertified*	Number who did not recertify**		
			Total	Number who re-enrolled within 31-60 days	Number who did not re-enroll or re-enrolled after more than 60 days
Aug-20	0	N/A	N/A	N/A	N/A
Sep-20	0	N/A	N/A	N/A	N/A
Oct-20	0	N/A	N/A	N/A	N/A
Nov-20	0	N/A	N/A	N/A	N/A
Dec-20	0	N/A	N/A	N/A	N/A

Source: For results from October 2019 through February 2020, enrollment data were obtained from DHCF Medicaid Management Information System (MMIS) data as of February 17, 2021. Recertification dates were obtained from DHCF MMIS data extracts as of the first week of each month shown, to reflect the recertification date that existed at that point in time.

Notes: Percentages in the table are out of the total number of Alliance enrollees with a recertification date in the month. Alliance enrollees who recertify or re-enroll include individuals who recertify or re-enroll in the Alliance or, in a small number of cases, Medicaid. Due to the public health emergency, Alliance enrollees had their coverage automatically extended starting in March 2020 and the "0" and “N/A” (not applicable) values reflect the fact that there were no Alliance enrollees required to recertify to maintain eligibility.

* Reflects individuals who were enrolled in any DHCF-funded program as of the month following their recertification date (i.e., continuously enrolled or re-enrolled within 30 days). Recertification dates are generally at of the end of the month, with a 30-day grace period. As a result, most beneficiaries who recertify are continuously enrolled and there are very few individuals who are terminated and then re-enroll within 30 days of their recertification date.

** Reflects individuals who were not enrolled in any DHCF-funded program as of the month following their recertification date.

Q36. Alliance enrollment increased by roughly 2,000 between the Mayor's PHE and the end of FY20. What is DHCF's enrollment projections through the financial plan if the Mayor's Alliance reforms remain in place? Please provide, in as much detail as possible, DHCFs methodology for projecting Alliance enrollment.

Response:

Please see "Q18 Attachment 1" for Alliance enrollment statistics with actual data through December 2020. This information is also updated monthly and readily available on the DHCF website: https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports.

As of the first quarter (Q1) Financial Review Process (FRP), DHCF projected an average monthly Alliance enrollment of 18,877 from January 2021 through September 2021. The Q1 FRP assumed that the federal public health emergency would extend through April 20, 2021, and that "the Mayor may extend the eligibility period for individuals receiving benefits, extend the timeframe for determinations for new applicants, and take such other actions as the Mayor determines appropriate to support continuity of, and access to, any public benefit program . . . until 60 days after the end of a public health emergency declared by the Mayor."[5] It also assumed that redeterminations of Alliance coverage, including the option of renewal by phone, would be phased in beginning in July 2021.

Enrollment projections beyond FY2021 are still in process and will not be available until the Mayor's FY22 budget is released.

[5] DC Act 23-247 § 303

Q37. Over the course of FY2020, Alliance enrollment increased significantly from a low of just over 15,000 to well over 17,000 by the end of the fiscal year. But compared to previous years, the Alliance expenditure balance did not see the same type of increase. What is the rationale for why the cost increase does not align with enrollment increase in FY 2020, especially given that Alliance has a per member per month cost structure, with the exception of emergency medical services?

Response:

While enrollment in the Alliance program grew from over 15,000 at the beginning of FY20 to over 17,000 at the end of that year, program cost depends on how many beneficiaries are enrolled each month. For example, the program could end the fiscal year with over 17,000 beneficiaries enrolled because of a surge in beneficiaries that occurred either early or late in the fiscal year. An increase that occurs early in the year would be much more costly than an increase that occurred later in the year. As a result, we measure enrollment in terms of average monthly enrollment for the year. The average monthly Alliance enrollment in FY20 was 15,982.

As noted in the question, the Alliance is primarily a capitated program, in which managed care organizations are given a per member per month rate for each beneficiary. Table 1 below shows the increases in the following:

a) Spending in the Alliance budget activity (Comprehensive Annual Financial Report [CAFR] spending),
b) Capitation spending after adjusting out accruals and the Health Insurance Provider Fee (HIPF) to get to a comparable basis,
c) Average monthly enrollment, and
d) The calculated average per beneficiary per month payment.

Table 1: Alliance Enrollment and Spending Changes, FY19 to FY20

Fiscal Year	2019	2020	% Growth
CAFR Spending	$77,031,593	$90,274,254	17.2%
Accrual	($3,427,265)	$0	
HIPF	$0	($2,127,747)	
Capitation Spending	$73,604,328	$88,146,507	19.8%
Average Monthly Enrollment	15,380	15,982	3.9%
Calculated Average Monthly Payment	$398.81	$459.62	15.2%

As shown in the table, capitation spending grew from FY19 to FY20 by just under 20 percent. This is the combined effect of a 3.9 percent increase in enrollment, and a 15.2 percent increase in the average amount paid, per month, for each beneficiary.

The increase in the per beneficiary amount is consistent with the 16.4 percent projected increase in the weighted average capitation rates for the Alliance assumed during FY20 budget formulation. The small difference is the impact of how the projected average was weighted versus actual experience, and the impact of FY20 mid-year rate adjustments to address adverse selection in the managed care program.

Q38. DHCF has mentioned that they are able to absorb the FY 2021 costs of the Mayor's Alliance reforms due to a downward revision in their enrollment projections after the FY 2021 Alliance budget was completed. That explains the FY 2021 budget, but how was the FY 2020 budget able to absorb the impacts of the Mayor's Alliance reforms in Q3 and Q4 of FY 2020 when enrollment was spiking?

Response:

The FY20 Alliance budget was based on an average monthly enrollment of 16,349. However, the actual Alliance experience in FY20 is best understood by looking at it in two parts: (1) the first six months, which was prior to the public health emergency (PHE), and (2) the last six months during the PHE. The average monthly enrollment in the Alliance from October 2019 through March 2020 was 15,484—well below budget assumptions. In fact, as of the FY20 Q1 FRP, DHCF was projecting an Alliance surplus of just over $1 million. The average monthly enrollment from April 2020 through September 2020 was 16,480—somewhat over the budget assumption. However, the savings from the first six months allowed DHCF to absorb most of the additional cost in the Alliance line. Please note, however, the Alliance did end FY20 with a shortfall of $449,694.

Q39. The FY 2020 CAFR states that "local funds were used to augment certain increased Human Support Services expenditures such as the higher costs of Medicaid programs and increased spending to provide assistance and support services due to COVID-19." Were any local funds that were freed up as a result of the increased 6.2% Medicaid match used to cover costs associated with the Mayor's Alliance reforms?

Response:

The local savings achieved as a result of the public health emergency and the enhanced FMAP of 6.2% supported a FY20 Alliance deficit of $449,694. DHCF is also projecting an Alliance deficit in FY21. It is also utilizing local savings that are available as a result of the continued enhanced FMAP to support the forecasted Alliance deficit of $2.7 million (based on the FY21 Q1 FRP).

Q40. Is the Department in compliance with the data collection requirements of the DC Healthcare Alliance Program Recertification Simplification Amendment Act of 2017? If so, please explain the Department's methods for collecting the data required by the Act. If not, please explain how the Department will comply with the Act's data collection requirements

Response:

Yes, DHCF is in compliance with the data collection requirements of the DC Healthcare Alliance Program Recertification Simplification Amendment Act of 2017 within the scope of our authority relating to enrollment, retention, and termination of Alliance coverage in Section 7d (1-4):

- The number of DC Health Care Alliance enrollees required to recertify;
- The number of DC Health Care Alliance enrollees required to recertify who successfully completed recertification;
- The number of DC Health Care Alliance enrollees who did not recertify; and
- The number of DC Health Care Alliance enrollees who re-enrolled in DC Health Care Alliance within 30 days after termination and the number of enrollees who re-enrolled within 60 days after termination.

DHCF is able to use data from the Medicaid Management and Information System (MMIS) to track these data elements. Please see question 35 for information related to recertifications. The Department of Human Services is responsible for collecting data relating to the remaining requirements under the Act.

Q41. Please provide copies of any public reports required by either the DC Healthcare Alliance Program Recertification Simplification Amendment Act of 2017 or the D.C. Healthcare Alliance Recertification Reporting Amendment Act of 2018

Response:

DHCF has complied with public reporting requirements under both Acts annually since enactment by reporting the required data to Council during its annual agency performance oversight. Please see the response to question 35 for the required data. Please see last year's response to question 38 of the FY19-20 Oversight Questions for the FY19 required data.

Q42. For the Alliance program please provide the following for FY20 and FY21, to date:

a. Services provided and eligibility requirements, including a description of and reason for any change or planned change in FY20 and FY21;

b. Reimbursement rates/methodologies, including a description of and reason for any change or planned change in FY20 and FY21; and

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

Response:

a. Alliance program services provided during FY20 and FY21 include:
- Primary care services;
- Specialist services;
- Outpatient hospital services;
- Inpatient hospital services;
- Adult wellness services;
- Pregnancy care;
- Urgent care services;
- Screening and stabilization of emergency medical conditions;
- Outpatient prescription drugs;
- Rehabilitation services;
- Home health care services;
- Adult dental services up to one thousand dollars ($1,000) annually;
- Emergency transportation services;
- Physical therapy, occupational therapy, and speech therapy;
- Nursing facility services; and
- Hemodialysis treatments.

There were no changes or planned changes to the services covered in the Alliance program for FY20 and FY21.

Current Alliance program eligibility requirements include the following financial and non-financial eligibility criteria:

(a) Aged 21 years or older;
(b) District residency;
(c) Provision of a Social Security Number (SSN), if obtained or available;
(d) Household income at or below 200% of the Federal Poverty Level (FPL), calculated based on historic Aid to Families with Dependent Children (AFDC) income methodology;
(e) Resources at or below $4,000 for a household composition of one person, or at or below $6,000 for a household composition of two people or more;
(f) Not eligible for or enrolled in Medicare or Medicaid, excluding eligibility for Medicaid payment for the treatment of an emergency medical condition pursuant to 42 C.F.R. §440.255; and

(g) Not enrolled in other third party medical or health coverage that meets the requirements of minimum essential coverage, as defined under 45 C.F.R. §156.600.

DHCF plans to transition eligibility criteria—through the promulgation of rulemaking in summer 2021—for Alliance to standards and methodology consistent with Medicaid Modified Adjusted Gross Income (MAGI) standards, effective on the date by which the District of Columbia Access System (DCAS) functionality for Alliance eligibility determinations is implemented. This transition will result in the following changes to Alliance eligibility requirements:

- Increasing household income eligibility threshold from 200% of the FPL to 210% of the FPL, plus a 5% income disregard;
- Eliminating the resource test;
- Changing household income methodology to MAGI tax-based standards from historic AFDC standards;
- Establishing DHCF's authority to suspend capitation payments to the Alliance beneficiary's managed care organization if the beneficiary becomes incarcerated; and
- Providing DHCF the authority to conduct periodic electronic data matches to update or confirm District residency between annual renewal periods, and to initiate termination of Alliance eligibility if an individual does not resolve the discrepancy.

DHCF will be proposing these changes because current eligibility standards are outdated and inconsistent with the standards that otherwise apply for Medicaid adults, resulting in a more complex eligibility assessment process. The new, MAGI-based standards will ensure equity and consistency with the District's income eligibility standards for non-disabled Medicaid-eligible adults, implemented under the Affordable Care Act. In addition, these standards will enable the District to implement a more streamlined eligibility methodology to support assessment for Medicaid and Alliance using the same eligibility factors. This change will allow for a simpler eligibility process for applicants and enable District caseworkers to spend less time managing the eligibility process for Alliance applicants and beneficiaries.

DHCF is also planning to establish a new Alliance eligibility group, also through rulemaking, for individuals who are determined to have been unjustly convicted of a crime in the District of Columbia, consistent with the requirements of the Unjust Imprisonment Act, effective December 13, 2017 (D.C. Law 22-151; D.C. Official Code §§ 2-421 et seq.). This change is planned for implementation in summer 2021.

DHCF also plans to implement additional changes to Alliance program policies and procedures required under changes to the DC Code. These are described in the responses to questions 44 and 45.

b. The District contracts with Mercer to develop actuarially sound capitation rates for the Alliance Program. Mercer analyzes the MCO-reported encounter data provided by the DHCF Fiscal Agent (Conduent) and financial data reported by the MCOs through various templates and workbooks. Detailed information on this data analysis is captured in Data

Books prepared for the 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. CMS does not review capitation rates developed for the Alliance Program.

In FY21, the Department of Health Care Finance made a policy change to the coverage of participants that have been diagnosed with Hepatitis C. Prior to the change the District required patients to have a fibrosis score of F2 or higher to access Hepatitis C curative treatments. Effective mid-year in FY21, the District has eliminated the requirement of the minimum fibrosis score for preferred orally administered direct acting antiviral medications Mavyret and Vosevi (including the generic versions).

c. For costs associated with the Alliance program, please see response to question 19. For enrollment and utilization data, please see "Q42 Attachment 1" and "Q42 Attachment 2".

Q43. Regarding the Health Care Alliance Program, for each month in FY20 and FY21 to date, please provide the total number of beneficiaries.

Response:

Please see "Q18 Attachment 1" for Alliance enrollment statistics. This information is also updated monthly and readily available on the DHCF website: https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports.

Q44. Please describe any changes to the administration of the Alliance program over FY20 and FY21 to date, including but not limited to:

a. Changes in how Alliance recertifications are processed by the service centers;

b. Changes in whether Alliance customers are permitted to drop off documents for an application or recertification without conducting a face-to-face interview if the service center is at capacity; and

c. Changes in the Department's policies and procedures for determining entitlement to a waiver of the face-to-face interview due to age, disability, or disability of a family member.

Response:

As the Department of Human Services handles the administration of the Alliance program, DHCF's response to this question focuses on policy changes related to the administration of the program.

In FY20, due to the COVID-19 public health emergency (PHE), the District amended eligibility rules for new applications to accept self-attestation for most eligibility requirements, including income and residency, for both the Medicaid and Alliance programs. In addition, during the PHE and for 60 days following the end of the PHE, face-to-face interviews are not required and coverage has been extended for Alliance beneficiaries without requiring the six month renewal, as declared by the Mayor.

Further changes, pending promulgation of rulemaking as noted above, and pursuant to the DC Health Care Alliance Recertification Simplification Act, effective December 13, 2017 (D.C. Law 22-35; D.C. Official Code § 7-1407 – 7-1408), are as follows: (1) an applicant or beneficiary that is caregiver for a household member who is hospitalized, disabled (including an individual who is pregnant in accordance with the additional requirements set forth under § 3301.8), or aged (65 years of age or older) may request an exemption from the in-person interview; (2) an in-person interview is only required once every 12 months; and (3) individuals may complete any additional required interviews for recertification over the phone with DHS.

Q45. Please describe any anticipated changes to the administration of the Alliance program over the remainder of FY21, including but not limited to:

- **a. Continuation of the ongoing suspension of recertification requirements as part of the Mayor's Public Health Emergency;**
- **b. Implementation of the DC Healthcare Alliance Program Recertification Simplification Amendment Act of 2017 once the Public Health Emergency-related suspension of recertification requirements ends; and**
- **c. Any other anticipated changes, whether related to the Public Health Emergency or not.**

Response:

a. The current suspension of the recertification requirements will continue for the duration of the COVID-19 PHE and for 60 days following the end of the PHE.

b. As described in the response to question 44, planned changes pursuant to the DC Healthcare Alliance Program Recertification Simplification Act of 2017 will be implemented, pending promulgation of rulemaking that codifies these requirements. Implementation of the rulemaking is slated for summer 2021.

c. As described in the response to question 42, additional changes, subject to the promulgation of rulemaking, include the following:
   (1) Transitioning eligibility criteria for Alliance to standards and methodology consistent with Medicaid Modified Adjusted Gross Income (MAGI) standards, effective on the date by which the District of Columbia Access System (DCAS) functionality for Alliance eligibility determinations is implemented;
   (2) Updating standards governing eligibility determinations and enrollment for Alliance program beneficiaries;
   (3) Streamlining Alliance eligibility policies and procedures to ensure greater parity with Medicaid eligibility standards and processes;
   (4) Establishing a new Alliance eligibility group for individuals who have been determined to have been unjustly convicted of a crime in the District of Columbia, consistent with the requirements of the Unjust Imprisonment Act, effective December 13, 2017 (D.C. Law 22-151; D.C. Official Code §§ 2-421 et seq.);
   (5) Establishing DHCF's authority to suspend capitation payments to the Alliance beneficiary's Managed Care Organization if the beneficiary becomes incarcerated; and
   (6) Providing DHCF the authority to conduct periodic electronic data matches to update or confirm District residency between annual renewal periods, and to initiate termination of Alliance eligibility if an individual does not resolve the discrepancy.

D. Supplemental Questions from the Community

COVID-19 Vaccination Planning and Implementation

Q46. How is DHCF partnering with DC Health on DC's COVID-19 vaccination plan?

Response:

The DC Health Scientific Advisory Committee for the Development and Implementation of a Safe, Effective, and Equitable COVID-19 Vaccine Distribution Program in the District of Columbia includes representation from DHCF. In this capacity, DHCF provides input to DC Health on effective strategies to communicate public health information regarding the safety and effectiveness of the vaccine in order to promote vaccine confidence and uptake; advises on messaging and outreach strategies to counter misinformation and to promote confidence among high-risk populations; and provides input on priorities for vaccination phases/tiers.

In addition, DC Health leadership has been actively involved in DHCF's efforts to plan for and conduct vaccine outreach to DHCF beneficiaries, and to assist managed care organizations with developing messaging and outreach strategies. DHCF has also provided data and information to DC Health, as needed, to facilitate vaccine outreach planning, including:

- Providing data to DC Health on where DHCF beneficiaries receive primary care services in order to inform future vaccine distribution;
- Informing DC Health regarding needs, challenges, and concerns regarding vaccination of residents receiving home health services; and
- Sharing data with DC Health from a phone survey of DHCF high-risk beneficiaries regarding vaccine receptivity to inform communication and outreach strategies.

Q47. How is the District, in coordination with Governor Hogan and Governor Northam, ensuring that DC Medicaid beneficiaries residing in Maryland and Virginia nursing facilities will be vaccinated and when?

Response:

DC Health is the agency primarily responsible for coordination of public health activities related to vaccination of DC residents in Maryland and Virginia nursing facilities. Beneficiaries in Maryland are subject to Maryland Health Department guidelines to coordinate vaccine administration. There are currently no DC Medicaid beneficiaries in Virginia nursing facilities.

DC Medicaid Managed Care Organizations and Plans

Q48. For each DC Medicaid Managed Care Organization in FY 2020, and FY 2021 to date, please provide the number of Medicaid State Plan beneficiaries transitioned onto the plan.

Response:

There were a total of 16,684 Medicaid beneficiaries who were transferred from fee-for-service to a managed care organization (MCO) beginning October 1, 2020 as part of the transition associated with FY21 DHCF policy and MCO contract changes.[6] These transition beneficiaries were age 21 or older and not dually eligible for Medicare. As noted below, an additional 324 individuals have enrolled in the new mandatory MCO groups in FY21 since the initial transition in October 2020.

- The majority of individuals (14,089) who transitioned as of October 1, 2020 were in groups not previously required to enroll in MCOs (e.g., those eligible for Medicaid based on receipt of Supplemental Security Income assistance).
- The remaining individuals (2,595) were in existing mandatory MCO groups but had an opt-out or other special circumstance that previously allowed them to remain in fee-for-service (e.g., HIV diagnosis).
- Since the initial transition in October 2020, an additional 324 individuals have enrolled in the new mandatory MCO groups in FY21 (November 2020 to March 2021). DHCF is not able to track new beneficiaries in the old mandatory MCO groups who previously could have opted out of MCO enrollment.

The number of new MCO beneficiaries who transitioned as of October 2020 were initially divided evenly for enrollment across the three full risk managed care plans (AmeriHealth, CareFirst, and MedStar) through an auto-assignment process. After receiving notice of their auto-assignment into an MCO, all beneficiaries were permitted to select a new MCO through December 2020 if they wished to select a different MCO plan. The number currently enrolled in the new mandatory MCO groups is provided in Table 1, below, by managed care plan. As noted above, DHCF cannot track the total number of "opt out" beneficiaries in the old mandatory MCO groups in a consistent manner.

Table 1: Number of Medicaid Beneficiaries in New Mandatory MCO Groups by Managed Care Plan, March 2021

Plan	Number of Beneficiaries
Total	**13,548**
AmeriHealth	5,410
CareFirst	4,008
MedStar	3,969
HSCSN[1]	1
Fee-for-Service[2]	160

Source: DHCF Medicaid Managed Care Information System data extracted March 9, 2021.

[6] The transition did not apply to beneficiaries enrolled with the Health Services for Children with Special Needs (HSCSN) plan.

Notes: Reflects beneficiaries in groups not required to enroll in MCOs prior to FY2021 (e.g., those eligible for Medicaid based on receipt of Supplemental Security Income assistance), who are age 21 or older and not dually eligible for Medicare. The total number of beneficiaries as of March 2021 (13,548) is smaller than the number who transitioned as of October 2020 (14,089) because the number who subsequently moved to a non-MCO group (e.g., due to gaining Medicare dual status) or disenrolled from Medicaid (e.g., due to death, a move out of the District, or voluntary request for termination) exceeds the number who newly enrolled.

[1] Even after moving to an eligibility group with mandatory MCO enrollment, beneficiaries under age 26 enrolled in the Health Services for Children with Special Needs (HSCSN) plan may continue their enrollment with HSCSN.

[2] Reflects recently enrolled beneficiaries who have not yet selected or been assigned to an MCO. The period of fee-for-service enrollment is typically less than three months for these individuals, not ongoing enrollment.

Q49. For each DC Medicaid Managed Care Organization in FY 2019, FY 2020, and FY 2021 to date, please provide: a) the per-member per-month amount spent on services and supports, b) the number of providers in the MCO's provider network, by District ward, c) the names of the providers in the MCO's provider network serving more than 25 individuals receiving Medicaid.

Response

a. Please see Table 1, below, for the weighted average per member per month payment to each managed care organization (MCO). Please note that DHCF pays MCOs based on actuarially sound capitation rates specified in the MCO contracts. These rates vary based on the age and sex of the beneficiary and the MCO. DHCF divided total payment to each MCO for each of the specified periods on a date-of-payment basis by the number of beneficiaries assigned to each MCO for the period based on enrollment data to compute the weighted average payment. Because there can be small misalignments between date-of-payment data and enrollment, the amounts below should be considered best estimates of the weighted averages.

Table 1: Average Per Beneficiary Per Month Payment to MCOs

MCO	FY 2019	FY 2020	FY 2021 Q1
AmeriHealth	$379.59	$413.73	$487.71
Amerigroup	$359.80	$312.26	
MedStar			$470.79
CareFirst/Trusted	$347.87	$311.16	$479.83
HSCSN	$2,906.58	$2,948.42	$2,939.17

b. Please see "Q49 Attachment 1" for information on the number of providers in the MCOs' provider network, by District Ward.

c. Please see "Q49 Attachment 1" for the name of the providers in the MCOs' provider network serving more than 25 individuals receiving Medicaid through the managed care program.

Q50. Please provide an update on the progress of the rollout of the Highly Integrated Dual Eligible Special Needs Plan (D-SNP) that began January 1, 2021.

Response:

The implementation of the Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP), originally slated for January 1, 2021, has been delayed to January 1, 2022. This delay was determined necessary given the other competing challenges in the health care system during the COVID-19 public health emergency. Stakeholders were notified of this delay in April 2020. DHCF continues its planning and development in earnest on this project, including provider and beneficiary engagement efforts, program design and development, procurement planning, and more. Additionally, the existing dual eligible special needs plan (D-SNP) continues apace, with two Medicare Advantage health plans and with interim program changes in place to help transition the system to the HIDE SNP model in 2022.

Q51. How does DHCF define home health services in its managed care model? What home health aide services are reimbursed under Managed Care Organization home health services?

Response:

DHCF defines home health services as described in 42 C.F.R. §§ 440.70. Home health care services can be furnished in any community setting, including a home, a residential facility, or a shelter. These services are furnished by registered nurses, licensed practical nurses, physical/occupational speech therapists, and/or licensed social workers.

Home Health Care Services consists of the following:

- Wound Care;
- Physical, Occupational and Speech Therapy;
- Health Education;
- Home IV-therapy;
- Routine visits to ascertain patient health status, check on the status of wounds, prescription drug monitoring; and
- Home visits to assess readiness prior to discharge.

MCOs reimburse personal care aide (PCA) services for individuals who provide services through a provider agency to assist the beneficiary in activities of daily living, (i.e., bathing, dressing, toileting, ambulation, or eating).

Q52. How is DHCF ensuring each Managed Care Organization provides for smooth transition and continuity of care in services for people currently under the fee for service model?

Response:

DHCF has several measures in place to ensure that the managed care organizations (MCOs) are providing a smooth transition and continuity of care for beneficiaries who transitioned from fee-for-service (FFS) on October 1, 2020. One such measure is requiring MCOs to establish policies and procedures for the secure transfer of medical information, continuity of care, and linking medical information for enrollees who have been transferred between plans.

In addition, DHCF shared prior authorization (PA) data with all MCOs so that beneficiaries in active treatment did not experience any interruption in care and services. DHCF continued this process for beneficiaries who chose to transfer from one MCO to another. The MCOs honored active PAs in place on October 1, 2020 until the authorization ended, or through December 31, 2020—whichever came first. All PAs for personal care aide (PCA) services will be honored for the full authorization period. The MCOs agreed to honor active referrals and PAs issued before October 1, 2020 and reimburse at the previous reimbursement rate.

The rendering provider was given the opportunity to enroll in the new MCO's network during the period of October 1, 2020 through December 31, 2020, to retain the beneficiary and provider relationship. If enrollment did not occur, the MCO remained obligated to assist the beneficiary with coordination of their health care needs through a different provider. The beneficiary also has the option of changing health plans if their doctor is not enrolled in their newly assigned MCO's provider network.

Another way DHCF is ensuring a smooth transition is to require the MCOs to provide care coordination and other services that are not available in FFS. Former FFS beneficiaries now have access to care coordinators who:

- Partner with the beneficiary to develop a care plan that identifies and addresses their needs, ensuring to receive the appropriate care and service;
- Assist with scheduling appointments with providers;
- Review doctor instructions with the beneficiary and family;
- Assist beneficiaries with managing medications;
- Conduct follow-up after a hospitalization or an emergency room visit; and
- Assist with other social factors that may impact the beneficiaries' well-being, such as housing, employment, legal help, food security, transportation, and childcare.

Q53. What outreach has DHCF conducted to inform beneficiaries of the transition to Managed Care Organizations?

Response:

DHCF conducted various outreach activities to inform beneficiaries of the transition to the managed care program and MCOs. Table 1, below, includes a list of activities completed by DHCF staff, the District's contracted Enrollment Broker, and other support through contracted outreach.

Table 1: Outreach Activities to Support Beneficiaries in the Managed Care Transition

Timeframe	Action
June 2020	Postcards mailed to impacted beneficiaries to alert of upcoming Medicaid reform and available health plans intended for the new managed care program.
August 2020	Text messages sent to beneficiaries with documented cell numbers to alert that there may be a change in their service delivery system or health plan.
August and September 2020	Town Halls targeted to beneficiaries and providers to inform of Medicaid reform including Managed Care Transition and Reassignment.
September 2020	Letters sent to beneficiaries to officially announce the new health plans in the managed care program.
September 2020	Letters mailed to beneficiaries to alert of their health plan assignment and steps to be taken if they want to change health plans.
September – October 2020	Welcome Packages mailed to all managed care beneficiaries introducing new health plan and included information for selecting a health plan of choice.
June – December 2020	Community stakeholders (providers and advocacy groups) assisted with disseminating information about Medicaid reform and selecting a health plan of choice.

Q54. How is DHCF monitoring the transition of beneficiaries from Fee-for-Service DC Medicaid to Managed Care?

Response:

DHCF conducts routine monitoring activities of the MCOs that includes oversight of operations, finance, provider network management, medical management, timely claims payments and service delivery. These activities continue and are applicable to the transitioned FFS beneficiaries that are now enrolled in an MCO. DHCF staff analyze regulatory reports required for submission by each MCO on recurring and established dates. The data is tracked and trended to evaluate performance within administration of managed care services by each health plan.

Routine meetings are convened monthly and quarterly with each individual health plan and collectively for opportunities for collaboration, troubleshooting, and to share MCO and Medicaid updates. Specifically, meetings are convened with clinical staff to assess case management activities for all enrolled beneficiaries, including targeted discussions for evaluation of performance outcomes related to the newly transitioned FFS beneficiaries.

DHCF staff performs monitoring activities that are aligned with Standard Operating Procedures (SOPs) and federal guidelines used to ensure consistent and uniform oversight amongst the distinctive MCOs.

Please see response to question 52 for additional information.

Q55. Has DHCF received any complaints regarding transition from Fee-for-Service DC Medicaid to Managed Care? If so, please provide the content and DHCF's response to each complaint.

Response:

Beginning FY21, DHCF received a number of complaints regarding the transition of beneficiaries from FFS Medicaid to managed care. Specifically, the District's contracted Enrollment Broker (Maximus), the entity responsible for enrolling eligible beneficiaries into an MCO, began to receive a high volume of calls and complaints during the first week of October 2020 that continued through mid-November 2020. These calls were in response to the District's assignment and reassignment of the transitioned FFS and existing eligible managed care populations amongst the three new MCOs, respectively.

The top five reasons for the calls and complaints included the following:

1. Former FFS beneficiaries complained about the transition to managed care absent their consent and requested to return to the FFS program.

   DHCF responded that correspondence was mailed via an initial postcard in June 2020, a second postcard was sent in September 2020 and a letter and Welcome Packet was also sent in September 2020 to the address on file with the Economic Security Administration (ESA). We further explained that consent was not required, and they no longer meet the criteria for the FFS program. Information was shared about the availability of expanded services, including case management and other value-add services to support their health care needs.

2. Complaints that notification about the transition was not received, resulting in unawareness of the change for accessing Medicaid services.

   For those beneficiaries who did not receive the notices, staff with Maximus and DHCF educated beneficiaries about the recent change to the Medicaid managed care program and assisted with selecting an MCO of their choice. Anyone dissatisfied with the auto assigned MCO, was given until December 31, 2020 to select another available MCO.

3. Complaints that beneficiaries experienced long hold times when calling the Enrollment Broker to select another MCO or to obtain more information about changes to the program. During the first full week of October 2020, over 10,000 calls (duplicate and unique) were registered with the Call Center resulting in a 70 percent abandonment rate.

   To mitigate the increase in call volume, DHCF implemented both an Enrollee Hotline and Provider Hotline. DHCF commissioned agency staff to the Enrollee Hotline to assist enrollees with enrollment and access to care concerns. DHCF staff were required to answer calls from the Enrollee Hotline for a minimum of four hours each day, extending past normal business hours.

DHCF approved the Enrollment Broker to hire 10 additional staff to manage calls coming through the Call Center. The additional staff began on the week of October 26 and within 30 days the call volume decreased by 79 percent and the call abandonment rate decreased by 88 percent.

4. Complaints regarding the inability to obtain medications when presented at the pharmacy.

   DHCF responded by assisting the beneficiary with obtaining their medications. Warm transfers were made to the respective MCOs to expedite overrides of prior authorization requirements and access to prescribed medications. MCOs were instructed to provide a 90-day supply through the transition period when requested and notification was sent to the pharmacy community instructing prompt delivery of medications despite the MCO enrollment – all claims were guaranteed for reimbursement as directed by DHCF.

5. Complaints from providers about the requirement to enroll with an MCO if seeking to continue service delivery to the transitioned FFS population.

   DHCF responded with a series of provider forums in collaboration with the MCOs. Providers were informed of the requirements for enrollment with an MCO, as necessary to continue service delivery and receive reimbursement past the 90-day transition period of October through December 2020. During the 90-day transition period, all eligible providers rendering care and service to a new or existing managed care beneficiary were reimbursed the same fees paid prior to the transition on September 30, 2020.

   The MCOs presented information about the credentialing process, provided critical points of contact with their respective organizations to attempt a smooth transition into their provider networks.

Please see the response to question 53 for additional information; providers and beneficiaries participated in virtual stakeholder and town hall meetings to learn more about the transition and ask questions for clarity.

DC Medicaid EPD Waiver and State Plan Long Term Care Supports and Services

Q56. How many unique individuals received EPD Waiver services in FY 2020? How many at end of FY 2021 Q1?

Response:

4,498 unique individuals received Elderly and Persons with Physical Disabilities (EPD) Waiver services in FY20 and, 4,715 unique individuals received EPD Waiver services as of the end of first quarter of FY21.

Q57. For EPD Waiver beneficiaries, when will DHCF begin implementing the approved 16-hour cap on personal care aide services?

Response:

DHCF will begin implementing the approved 16-hour cap on personal care aide services for Elderly and Persons with Physical Disabilities (EPD) Waiver beneficiaries at the conclusion of the federal public health emergency.

Q58. For each FY 2019, FY 2020, and FY 2021 to date, please provide the number of DC Medicaid beneficiaries under the State Plan and EPD Waiver who received the Personal Emergency Response Systems (PERS) service.

Response:

Table 1, below, provides the number of beneficiaries who received the PERS service under the Elderly and Persons with Physical Disabilities (EPD) Waiver in FY19, FY20, and FY21 to date.

Table 1: EPD Waiver Beneficiaries receiving the PERS service

Fiscal Year	Number of Beneficiaries
FY19	1,949
FY20	2,571
FY21, to date	1,948

The District implemented a change to policy effective October 1, 2020 that allows DHCF to reimburse for PERS and another medical assistive devices and services under the Medicaid State Plan and for beneficiaries who qualify who are not enrolled in the EPD waiver program, and in February 2021 approved the first provider enrollments under the new policy. DHCF has completed important system processes that allow us to pay providers under this new authority but has not yet reimbursed for PERS under the State Plan. We expect to begin doing so within the coming weeks.

Q59. How many EPD Waiver providers were certified to provide the following for each FY 2019, FY 2020, and FY 2021 to date:

- **Homemaker services;**
- **Chore aide services;**
- **Physical or occupational therapy services;**
- **Adult Day Health services;**
- **Community transition services.**

Response:

Please see table 1, below, for the number of Elderly and Persons with Physical Disabilities (EPD) Waiver providers certified to provide each of the services requested in FY19, FY20, and FY21 to date.

Table 1: Certified EPD Waiver Providers, by Service

Service	FY19	FY20	FY21 (to date)
Homemaker	3	3	3
Chore aide services	3	3	3
Physical Therapy*	15	15	15
Occupational Therapy*	15	15	15
Adult Day Health	8	8	9
Community Transition Services	1	1	1

**Note: PT and OT services were removed from the Waiver as of 10/1/2020 as they are accessed via the State plan. However, we have reported the number of enrolled home health agency providers that are licensed to provide this service.*

Q60. How many unique individuals are authorized to receive each of the above listed services under the EPD Waiver for each FY 2019, FY 2020, and FY 2021 to date?

Response:

Please see table 1, below, for the number of Elderly and Persons with Physical Disabilities (EPD) Waiver beneficiaries authorized to receive each of the services requested in FY19, FY20, and FY21 to date.

Table 1: EPD Waiver Beneficiaries Authorized to Receive Services

Service	FY19	FY20	FY21 (to date)
Homemaker	16	41	83
Chore aide services	10	14	25
Physical Therapy	3	17	16
Occupational Therapy	26	64	45
Adult Day Health	3	8	11
Community Transition Services	24	24	3

Q61. How many grievances were filed against DHCF providers and DHCF during FY 2020? How many of these grievances did DHCF find in favor of the beneficiary?

Response:

Per DHCF's Customer Service Tracking System, 53 long term care-related complaints were filed against DHCF providers and DHCF during FY20.

While we are able to track when a complaint is resolved and the categories into which they fall, we cannot track the outcome of each complaint.

Questions Concerning DC Medicaid for Children and Youth

Q62. How many unique children and youth (under the age of 21) were enrolled in Medicaid at the end of FY 2020 Q2 (3/31/20), FY 2020 Q3 (6/30/20), FY 2020 Q4 (9/30/20)? How many at the end of FY 2021 Q1 (12/31/20)? How many children and youth are enrolled in the District's fee-for-service Medicaid? How many enrolled in each of the District's Managed Care Organizations (MCOs)?

Response:

Please see table 1, below, for the number of unique children and youth enrolled in Medicaid by fee-for-service and each managed care organization (MCO).

Table 1: Number of Unique Children and Youth Under Age 21 Enrolled in Medicaid by FFS or MCO Status, FY20 Q2-Q4 and FY21 Q1

	FY20 Q2	FY20 Q3	FY20 Q4	FY21 Q1
Fee-for-Service	9,274	8,056	7,297	6,509
MCO	81,905	85,049	87,330	89,219
- Amerigroup	15,066	15,921	16,489	0
- AmeriHealth	51,526	53,089	54,410	38,934
- CareFirst	11,103	11,797	12,193	22,869
- HSCSN	4,210	4,242	4,238	4,232
- MedStar	0	0	0	23,184
Total Enrollment	**91,179**	**93,105**	**94,627**	**95,728**

Source: Data extracted from DHCF's Medicaid Management Information System on March 3, 2021.
Notes: FFS is fee-for-service; MCO is managed care organization; HSCSN is Health Services for Children with Special Needs. Enrollment (including FFS and MCO) was captured as of the last month of each quarter in question. Due to insufficient run-out, data reported for FY2021 Q1 will likely increase in the future.

Q63. At the beginning of FY 2020 Q1 (10/1/19), how many unique children and youth enrolled in Medicaid had been diagnosed with a "serious emotional disturbance"? How many at end of FY 2020 Q4, September 30, 2020? How many at end of FY 2021 Q1?

Response:

Please see table 1, below, for the number of unique children and youth with a serious emotional disturbance enrolled in Medicaid by fee-for-service and each managed care organization (MCO).

Table 1: Number of Unique Children and Youth Under Age 21 Enrolled in Medicaid Diagnosed with a Serious Emotional Disturbance, FY20 Q1 and Q4, and FY21 Q1

FFS or MCO Enrollment	FY20 Q1	FY20 Q4	FY21 Q1
Fee-for-Service	302	276	278
Amerigroup	236	258	0
AmeriHealth	1,079	1,037	716
CareFirst	155	141	293
HSCSN	261	264	263
MedStar	0	0	298
Total	**2,033**	**1,976**	**1,848**

Source: Data extracted from DHCF's Medicaid Management Information System on March 3, 2021.
Notes: FFS is fee-for-service; MCO is managed care organization; HSCSN is Health Services for Children with Special Needs; SED is serious emotional disturbance, based on diagnosis codes identified by DBH clinical staff. Enrollment (including FFS and MCO) was captured as of the last month of each quarter in question, and claims were analyzed to capture diagnoses and utilization for the 3 months prior to the month of enrollment. For example, a child enrolled as of December 2020 was considered enrolled at the end of FY2021 Q1 and claims reflected dates of service from October 1, 2020 – December 31, 2020. Analysis includes fee-for-service claims and managed care organization encounters and was restricted to paid, final records with dates of service in the quarters shown. Due to insufficient claims lag, data reported for FY2021 Q1 will likely increase in the future.
* Due to a reprocurement of MCO contracts, Amerigroup was discontinued and MedStar was added as a plan as of FY2021. In addition, existing MCO beneficiaries were auto-assigned to new plans as of October 2020, with an option to select a different plan through December 2020.

Q64. At the beginning of FY 2020 Q1, how many unique children and youth enrolled in Medicaid diagnosed with a "serious emotional disturbance" were receiving services from a behavioral health service provider other than a CSA, including services provided by CFSA, DYRS, DHS, and Free-Standing Clinic Providers? How many as of end of FY 2020 Q4, September 30, 2020? How many as of end of FY 2021 Q1? Please list these non-CSA behavioral health service providers and indicate for each what service they provide.

Response:

Table 1, below, provides information on the number of unique children and youth under age 21 enrolled in Medicaid diagnosed with a serious emotional disturbance who received services from selected behavioral health service providers other than a Core Service Agency (CSA) for FY20 Quarter 1 (Q1), FY20 Q4, and FY21 Q1. In particular, services provided by federally qualified health center (FQHC) behavioral health and freestanding mental health clinic providers are shown in the data table.

Other non-CSA provider types may deliver behavioral health services but are not included in the data table. DHCF's ability to identify these services is limited, either due to a lack of standard definitions or incomplete data reporting. Regarding definitions, for example, there is no standard methodology for identifying the behavioral health services provided by physicians. Regarding data reporting, some of the non-CSA provider types named in this question do not bill DHCF, and some that bill are not readily identifiable to allow for a complete accounting. For example, other licensed behavioral health practitioners (e.g., psychologists, social workers, professional counselors, marriage/family therapists) are covered under fee-for-service as of calendar year 2020 under DHCF's Behavioral Health Transformation Demonstration and can be identified; however, DHCF's ability to identify the service utilization for managed care enrollees is limited due to incomplete historical data on the providers enrolled with each plan.

In addition, while some MHRS providers are not CSAs, CSAs deliver the vast majority of services and current data in MMIS does not allow for DHCF to differentiate between CSA and non-CSA providers. As requested, the data provided excludes CSAs, which provide the majority of Mental Health Rehabilitation Services (MHRS).

Table 1: Number of Unique Children and Youth Under Age 21 Enrolled in Medicaid Diagnosed with a Serious Emotional Disturbance and Receiving Services from Selected Behavioral Health Service Providers, FY2020 Q1 and Q4 and FY2021 Q1

FFS or MCO Enrollment	Number with SED	Number with Services from FQHC Behavioral Health	Number with Services from Freestanding Mental Health Clinic	Total Unique Children with SED with FQHC or Freestanding Services
FY20 Q1				
Fee-for-Service	302	27	40	**64**
Amerigroup	236	46	35	**80**
AmeriHealth	1,079	159	192	**343**
CareFirst	155	30	28	**58**
HSCSN	261	22	71	**92**

FFS or MCO Enrollment	Number with SED	Number with Services from FQHC Behavioral Health	Number with Services from Freestanding Mental Health Clinic	Total Unique Children with SED with FQHC or Freestanding Services
MedStar	0	0	0	**0**
Total	**2,033**	**284**	**366**	**637**
FY20 Q4				
Fee-for-Service	276	0	34	**34**
Amerigroup	258	33	31	**64**
AmeriHealth	1,037	157	136	**288**
CareFirst	141	28	12	**39**
HSCSN	264	12	67	**77**
MedStar	0	0	0	
Total	**1,976**	**230**	**280**	**502**
FY21 Q1				
Fee-for-Service	278	0	29	**29**
Amerigroup	0	0	0	**0**
AmeriHealth	716	100	87	**185**
CareFirst	293	26	19	**44**
HSCSN	263	9	51	**59**
MedStar	298	6	6	**12**
Total	**1,848**	**141**	**192**	**329**

Source: Data extracted from DHCF's Medicaid Management Information System on March 3, 2021.
Notes: FFS is fee-for-service; MCO is managed care organization; HSCSN is Health Services for Children with Special Needs; SED is serious emotional disturbance, based on diagnosis codes identified by DBH clinical staff. Enrollment (including FFS and MCO) was captured as of the last month of each quarter in question, and claims were analyzed to capture diagnoses and utilization for the 3 months prior to the month of enrollment. For example, a child enrolled as of December 2020 was considered enrolled at the end of FY2021 Q1 and claims reflected dates of service from October 1, 2020 – December 31, 2020. Due to insufficient claims lag, data reported for FY2021 Q1 will likely increase in the future. Analysis includes fee-for-service claims and managed care organization encounters and was restricted to paid, final records with dates of service in the quarters shown. A federally qualified health center (FQHC) behavioral health provider was defined by an FQHC billing provider type code X05 and an FQHC behavioral health billing provider specialty code 800. Freestanding mental health clinic was defined by billing provider type code X02; this includes services billed by the Department of Behavioral Health, which is registered with DHCF as a freestanding provider. Because this table reflects only selected provider types (e.g., it excludes CSA, CFSA, DYRS, and DHS providers), it does not reflect the total number of children with SED that received a behavioral health service.
* Due to a reprocurement of MCO contracts, Amerigroup was discontinued and MedStar was added as a plan as of FY2021. In addition, existing MCO beneficiaries were auto-assigned to new plans as of October 2020, with an option to select a different plan through December 2020.

DHCF is authorized to reimburse for non-CSA behavioral health services provided by free-standing mental health centers, clinics, FQHCs, physicians, and local education agencies (LEAs). CFSA provides services to covered Medicaid beneficiaries through a CFSA-operated clinic. While neither DYRS nor DHS are enrolled as providers of behavioral health services covered by Medicaid, DYRS bills DHCF for services provided to Medicaid-enrolled children and youth. The services covered by Medicaid-covered entities and the authority for Medicaid coverage of these services is included in the Table 2, below.

Table 2: Covered Services for non-CSA Providers, by Provider Type

Provider Type	Services Provided	Authority
Freestanding Mental Health Clinics (FSMHCS)	Health Home service coordination, individual psychotherapy, prescription visits, family therapy, family conferences, complete psychological testing, and group therapy services.	29 DCMR § 800 et seq.; 29 DCMR § 6900 et seq.; 22-A DCMR § 3400 et seq; Attachment 3.1-A, Section 9 of the Medicaid State Plan; Supplement 1 to Attachment 3.1-A, Section 9 of the Medicaid State Plan; Attachment 3.1-B, Section 9 of the Medicaid State Plan; Supplement 1 to Attachment 3.1-B, Section 9 of the Medicaid State Plan
Federally Qualified Health Centers (FQHC)	Limited ambulatory mental health and substance abuse evaluation, treatment and managed services.	29 DCMR § 4500 et seq.; Attachment 3.1-A, Supplement 1 to Attachment 3.1-A of the Medicaid State Plan; Supplement 1 to Attachment 3.1B of the Medicaid State Plan
Physicians	Individual, group and family psychotherapy, psychoanalysis, and psychiatric diagnostic services, only by qualified physicians.	29 DCMR § 909; 29 DCMR § 995; Attachment 3.1-A, Section 5 of the Medicaid State Plan; Supplement 1 to Attachment 3.1-A, Section 5 of the Medicaid State Plan; Attachment 3.1-B, Section 5 of the Medicaid State Plan; Supplement 1 to Attachment 3.1-B, Section 5 of the Medicaid State Plan
Other Licensed Providers	Individual or groups of licensed providers including psychologists, Licensed Independent Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists can obtain Medicaid reimbursement for assessment, diagnostic, and screening services and psychological testing.	Section 1115 Medicaid Behavioral Health Transformation Demonstration (2020); Supplement 1 to Attachment 3.1-A of the Medicaid State Plan (pending approval, 2022); 29 DCMR §990

Q65. How many unique children and youth enrolled in Medicaid and diagnosed with a "serious emotional disturbance" received inpatient behavioral health treatment at either the Psychiatric Institute of Washington or Children's National Hospital during FY 2020? How many during FY 2021 Q1?

Response:

Please see Table 1, below, for the number of unique children and youth under age 21 enrolled in Medicaid and diagnosed with a serious emotional disturbance who received inpatient behavioral health treatment at the Psychiatric Institute of Washington (PIW) or Children's National Hospital. In response to question 67, a breakout is provided for each Medicaid managed care organization (MCO).

Table 1: Number of Unique Children and Youth Under Age 21 Enrolled in Medicaid Diagnosed with a Serious Emotional Disturbance and Receiving Inpatient Behavioral Health Treatment from Selected Providers, FY20 and FY21 Q1

FFS or MCO Enrollment	FY20		FY21 Q1	
	Children's Hospital	PIW	Children's Hospital	PIW
Fee-for-Service	65	41	11	11
Amerigroup	33	9	0	0
AmeriHealth	122	53	13	17
CareFirst	20	9	4	11
HSCSN	104	49	35	12
MedStar	0	0	11	4
Total	**344**	**161**	**74**	**55**

Source: DHCF Medicaid Management Information System (MMIS) data as of March 2, 2021.
Notes: FFS is fee-for-service; MCO is managed care organization; HSCSN is Health Services for Children with Special Needs. Serious emotional disturbance is based on diagnosis codes identified by DBH clinical staff. Enrollment (including FFS and MCO) was captured as of the last month of the time period, and claims were analyzed to capture diagnoses and utilization for the time period (FY2020 or FY2021 Q1). Analysis includes fee-for-service claims and managed care organization encounters and was restricted to paid, final records with dates of service in the periods shown. Due to insufficient claims lag, data reported for FY2021 Q1 will likely increase in the future.
* Due to a reprocurement of MCO contracts, Amerigroup was discontinued and MedStar was added as a plan as of FY2021. In addition, existing MCO beneficiaries were auto-assigned to new plans as of October 2020, with an option to select a different plan through December 2020.

Q66. How many unique children and youth enrolled in Medicaid and diagnosed with a "serious emotional disturbance" received the following services during FY 2020 and FY 2021 Q1: (1) Community-Based Intervention (CBI); (2) Assertive Community Treatment (ACT); (3) High Fidelity Wraparound (HFW); (4) Therapeutic Foster Care (TFC)? How were these services impacted by COVID-19?

Response:

Table 1, below, provides information on the number of children and youth under age 21 enrolled in Medicaid and diagnosed with a serious emotional disturbance who received Community-Based Intervention (CBI) and Assertive Community Treatment (ACT) paid by Medicaid. High Fidelity Wraparound (HFW) and Therapeutic Foster Care (TFC) services are not covered services under Medicaid and therefore the agency has no information on the number of Medicaid-eligible children who received these services at this time. In response to question 67, a breakout is provided for each Medicaid managed care organization (MCO).

In April 2020, DHCF released guidance that expanded the circumstances under which services can be billed as telehealth. During the COVID-19 pandemic, there has been an overall increase in mental health service utilization among DHCF Medicaid beneficiaries relative to pre-pandemic levels, with a substantial portion of the care being provided via telehealth. For CBI and ACT among Medicaid beneficiaries under age 21 in particular, a review of monthly data indicates that post-pandemic use of these services has been consistent with pre-pandemic utilization.

Table 1: Number of Unique Children and Youth Under Age 21 Enrolled in Medicaid Diagnosed with a Serious Emotional Disturbance Who Received Community Based Intervention or Assertive Community Treatment, FY20 and FY21 Q1

FFS or MCO Enrollment	Number with SED	Number with Community-Based Intervention	Number with Assertive Community Treatment	Total Unique Children with SED with CBI or ACT or Services
FY20				
Fee-for-Service	504	87	8	**95**
Amerigroup	464	21	0	**21**
AmeriHealth	1,922	106	9	**115**
CareFirst	295	13	1	**14**
HSCSN	435	65	19	**82**
Total	**3,620**	**292**	**37**	**327**
FY21 Q1				
Fee-for-Service	279	32	5	**37**
AmeriHealth	722	40	1	**41**
CareFirst	292	20	5	**25**
MedStar	305	15	0	**15**
HSCSN	263	31	14	**45**
Total	**1,848**	**138**	**25**	**163**

Source: Data extracted from DHCF's Medicaid Management Information System on March 3, 2021.

Notes: ACT is Assertive Community Treatment; CBI is Community-Based Intervention; FFS is fee-for-service; MCO is managed care organization; HSCSN is Health Services for Children with Special Needs; SED is serious emotional disturbance, based on diagnosis codes identified by DBH clinical staff. Enrollment (including FFS and MCO) was captured as of the last month of the time period, and claims were analyzed to capture diagnoses and utilization for the time period (FY2020 or FY2021 Q1). Due to insufficient claims lag, data reported for FY2021 Q1 will likely increase in the future. Analysis reflects fee-for-service claims (because ACT and CBI are reimbursed FFS even for children enrolled in an MCO) and was restricted to paid, final records with dates of service in the periods shown. CBI was identified using procedure code H0039 with a Mental Health Rehabilitation Services (MHRS) billing provider type. ACT was identified using procedure codes H2022 and H2033 with an MHRS billing provider type. Because this table reflects only selected services, it does not reflect the total number of children with SED who received a behavioral health service.
* Due to a reprocurement of MCO contracts, Amerigroup was discontinued and MedStar was added as a plan as of FY2021. In addition, existing MCO beneficiaries were auto-assigned to new plans as of October 2020, with an option to select a different plan through December 2020.

Q67. Can you please break down the number of youth receiving each service by Medicaid MCO?

Response:

Please see the responses to questions 64, 65, and 66 for the breakout of the number of youth under age 21 receiving services by Medicaid managed care organization (MCO) plan name. The number of children is also provided by Medicaid MCO for Question 63.

Q68. What is the number of children and youth who received ChAMPS services more than once in FY 2020? More than two times?

Response:

There were 339 children and youth under age 21 who received Children and Adolescent Mobile Psychiatric Service (ChAMPS) services at least once during FY20 with payment by DHCF.[7] Of these children and youth receiving ChAMPS, 231 who received ChAMPS services more than once (based on multiple dates of service) and 61 who received ChAMPS services more than two times.

[7] Data was extracted from DHCF's Medicaid Management Information System on March 3, 2021. Analysis was restricted to children under age 21 as of the date of service. ChAMPS services were defined as final, paid fee-for service claims billed with procedure code H2011 by Anchor Mental Health with a date of service in FY2020.

Q69. As of October 1, 2021, how many children and youth enrolled in Medicaid and diagnosed with a "serious emotional disturbance" will be required to enroll in a different Medicaid managed care organization ("MCO") than the one in which they are currently enrolled or be transferred from non-MCO-based Medicaid or Fee for Service?

Response:

DHCF does not have a policy of requiring children enrolled in Medicaid and diagnosed with a serious emotional disturbance to enroll in a different Medicaid managed care organization (MCO) than the one in which they are currently enrolled. Medicaid MCOs are required to cover the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service benefit. The EPSDT benefit covers any treatment and services that is needed for children diagnosed with serious emotional disturbance. Currently there are no plans to implement such a policy beginning FY22 (October 1, 2021).

Q70. What specific steps will DHCF take in the transfer of these children and youth? How will families be contacted to inform them of this transfer and what specific notice will be provided?

Response:

Please see the response to question 69, which explains no such transfer of these children and youth to another MCO or FFS has, nor will occur. Thus, specific notice is not required.

Q71. How many youths between the ages of 18 and 20 with serious emotional disturbance were transferred to either a new MCO or transferred from a non-MCO Medicaid system to an MCO during FY 20 and beginning October 1, 2020? How is DHCF following up to ensure all of these youth are continuing to receive appropriate mental health services of their choice?

Response:

There were 646 youths between the ages of 18 and 20 with serious emotional disturbance (SED)[8] enrolled with a managed care organization (MCO) who were transferred to a new MCO beginning October 1, 2020 as part of the auto assignment associated with FY21 DHCF policy and MCO contract changes.[9] All individuals were permitted to select a new MCO through December 2020 if they wished to change their auto-assigned plan. The FY21 changes did not include a transfer of beneficiaries under age 21 from a non-MCO Medicaid system (i.e., fee-for-service (FFS)) to an MCO, so no youths with SED were actively moved from FFS to an MCO beginning October 1, 2020.[10]

All MCOs have Case Managers (CMs) who specialize in behavioral health care and service coordination. These CMs work with their network of providers to cover and coordinate ambulatory mental health services and therapies. For Mental Health Rehabilitation Services (MHRS), DHCF ensures that MCOs are providing referrals to the Department of Behavioral Health (DBH) and its contracted providers to ensure that youth are continuing to receive appropriate care.

Children and youth who were admitted to Psychiatric Residential Treatment Facilities (PRTFs) as of, or on October 1, 2020 were not transitioned from FFS to an MCO. These children remained in FFS while in the PRTF and will be re-enrolled in an MCO once they are no longer in the PRTF.

[8] SED is based on diagnosis codes identified by DBH clinical staff on at least one DHCF claim in FY2020. Includes Medicaid and Immigrant Children's Program beneficiaries.
[9] Figure includes Medicaid and Immigrant Children's Program beneficiaries. The auto assignment did not apply to beneficiaries enrolled with the Health Services for Children with Special Needs (HSCSN) plan.
[10] When beneficiaries who are in a mandatory MCO group newly enroll with DHCF, they may have a brief period in fee-for-service before selecting or being assigned to an MCO. These routine transitions from fee-for-service to MCO continue to occur and are not affected by the FY2021 DHCF policy and MCO contract changes.

Q72. What specific outreach has DHCF made to families of children and youth to explain the transition process from youth services to adult services at the age of 18 and how is this taking place with the restrictions imposed by COVID-19?

Response

Beyond overall care coordination for all Medicaid beneficiaries, DHCF does not conduct specific outreach to families concerning the transition process to adult behavioral health services. DHCF works closely with the Department of Behavioral Health (DBH) on ensuring continuity of care for Medicaid beneficiaries, including those transitioning to adult behavioral health services. DHCF understands that Mental Health Rehabilitation Services (MHRS) and DBH providers work with youth and caregivers on transition planning as they come of age at 18 years old. In addition, DBH established a Transition Aged Youth (TAY) Division to support transition from children services to adult services. TAY have quarterly meetings, "TAY Takeover," to discuss services and ultimately create and implement a seamless process for youth as they transition from pediatric services to adult services. DHCF understands that DBH is also exploring a possible partnership with the National Alliance to Advance Adolescent Health to pilot the use of a navigation tool for TAY and families. This tool includes a readiness assessment for transition planning.

At this time, there have been no known restrictions imposed by COVID-19.

Q73. Did DHCF enter into any new MOUs in FY 2020 (or other partnerships) related to the provision of behavioral or mental health services for children and youth?

Response:

Yes, DHCF entered into the following Memoranda of Understanding (MOUs) related to the provision of behavioral or mental health services for children and youth:

(1) MOU between the DHCF and DBH to provide telehealth services to increase access to medication assisted treatment (MAT) to treat opioid use disorder (OUD) for District residents.
(2) MOU between the DHCF and DBH to provide 1115 Waiver services as a benefit of the District's Medicaid program.

Q74. In FY 2020, what was the overall denial rate for MHRS provider claims?

Response:

A total of 1,588,339 Mental Health Rehabilitation Services (MHRS) fee-for-service (FFS) claims with FY20 dates of service have been processed by DHCF to date.[11] Of these, 1,351,869 were paid and 236,470 were denied, for a denial rate of 14.9 percent.

[11] Data was extracted from DHCF's Medicaid Management Information System on March 5, 2021. Reflects final claims in paid or denied status billed with provider type T01 and a first date of service in FY2020. Claims count reflects unique TCNs, and denials were counted based on claim header information.

DC Medicaid PACE Program

Q75. Has the District selected a PACE provider? Please provide the details of the RFP, the provider selection criteria, and resulting contract, if any.

Response:

Two protests have been filed against the Programs of All-Inclusive Care for the Elderly (PACE) provider selection, so all provider enrollment processes have been suspended pending the outcome and guidance from the Office of Contracting and Procurement (OCP). The RFP, which opened on August 19, 2020 and closed on October 8, 2020, can be found on the on the OCP Transparency Portal by searching Solicitation Number Doc499430.

Q76. If a provider has been selected, has it received approval from CMS? Has DHCF and the provider signed a PACE program agreement?

Response:

Two protests have been filed against the Programs of All-Inclusive Care for the Elderly (PACE) provider selection, so all provider enrollment processes have been suspended pending the outcome and guidance from the Office of Contracting and Procurement. The Centers for Medicare and Medicaid Services (CMS) processes for approval and completion of a three-way agreement between the District and the PACE provider will proceed subsequent to the protest resolution.

Q77. Please provide an update on DHCF's PACE contract. Is a CBE subcontracting plan for the base period still required?

Response:

DHCF intends to award a contract to the selected provider after their approval as a provider by the Centers for Medicare and Medicaid Services (CMS). DHCF expects this will occur late in 2021. Certified Business Enterprise (CBE) subcontracting is not required for the base year.

Miscellaneous Questions

Q78. Please provide an update on DHCF's Enrollment Broker Contract. CW 43442

Response:

The current Enrollment Broker Contract with Maximus Health Services, Inc., CW43442, is ongoing and will continue until it is set to expire on August 11, 2021. The period of performance for the last option year is August 12, 2020 through August 11, 2021.

Since the current contract will soon expire, DHCF and the Office of Contracting and Procurement are working collaboratively to issue a new solicitation for these services. We are currently in the pre-solicitation phase of this procurement.

Q79. Will DHCF/MCOs cover the needs of people with Traumatic Brain Injury (TBI)/Acquired Brain Injury (ABI) and/or TBI/ABI with a co-occurring disorder of another covered illness?

Response:

DHCF recognizes the need for coverage of specialized provider types and services to more appropriately treat Acquired Brain Injury (ABI) among DHCF beneficiaries, as well as to better manage associated behavioral health symptoms among beneficiaries with ABI. However, DHCF is currently unable to meet these needs under current State Plan authority due to restrictions on provider types required to provide these services, as well as restrictions on the services themselves.

DHCF is working closely with the DC Acquired Brain Injury Workgroup and other stakeholders to identify options to cover the provider types and services needed to more appropriately address the needs of beneficiaries with ABI. The following options are currently being pursued:

- DHCF's plan to transition expiring services in the 1115 Medicaid Behavioral Health Transformation Waiver to the Medicaid State Plan beginning January 1, 2022 will create opportunities to enroll certain provider types required to provide ABI services, and will allow those provider types to provide some of the services needed by beneficiaries with ABI:
    - Effective January 1, 2022, the following independently licensed behavioral health practitioners (individual and group) shall be eligible to enroll in the DC Medicaid Program:
        - Psychologists;
        - Licensed Independent Clinical Social Workers;
        - Licensed Professional Counselors; and
        - Licensed Marriage and Family Therapists.
    - Medicaid reimbursement will be available for the following services, when provided to an eligible Medicaid beneficiary by an independently licensed behavioral health practitioner:
        - Assessment, Diagnostic, and Screening services; and
        - Psychological Testing.
    - Medicaid reimbursement will be available for the following services, when provided to an eligible Medicaid beneficiary diagnosed with a serious emotional disturbance, SMI, or SUD by an independently licensed behavioral health practitioner:
        - Counseling and Psychotherapy; and
        - Treatment Planning and Care Coordination.
- DHCF continues to explore options to add services to the fee schedule that may be required for ABI assessment and treatment beyond those listed above. As part of DHCF's plan to carve-in behavioral health services into Medicaid managed care beginning October 2022, DHCF is including Neurological Brain Injury in a request for proposals to conduct a comprehensive study to develop recommendations for reimbursement rates for behavioral health services.

Q80. For FY19, FY20, and FY21 to date, please provide the amount of dollars spent on behavioral health programs, services, and activities for children (ages 0-21) (including HealthCheck/EPSDTs, PRTFs, My DC Health Homes, and MyHealth GPS). If the program, service, or activity serves both children (ages 0-21) and adults, please include only the funding spent specifically on children (ages 0-21). Additionally, for each program, service, or activity, please provide a breakdown of the amount of local, federal, private, and special revenue funding for FY19, FY20, and FY21 to date.

Response:

Please see "Q82 Attachment 1" for the amount of dollars spent on behavioral health programs, services, and activities for children. The following assumptions were used to determine the information in the attached:

- The information is a combined dataset using Medicaid Management Information System (MMIS) and System of Accounting and Reporting (SOAR) data to capture the elements of the questions asked.
- Expenditures are based on children ages 0 to 20 years of age.
- Children do not receive services through DC Health Homes.
- The Children's Health Insurance Program (CHIP) federal match varied during the period of the data:
    - FY19 was 100% federal match
    - FY20 quarter one (Q1) was 90.5% federal match and Q2 and Q3 were 94.8% federal match
    - FY21 has reverted to the traditional CHIP match and includes the Enhanced Federal Medicaid Participation (EFMAP) for a total 83.3% federal match.
- The Medicaid funding includes the Enhanced Federal Medicaid Participation (EFMAP) beginning in FY20 Q2 through current for a 76.2% federal match. Prior to that, federal match was 70%.

Q81. Please include a description of efforts to allow behavioral health providers to bill for collateral contacts in FY20 and in FY21, to date.

Response:

In FY13, DHCF reviewed federal and state laws defining collateral contacts. DHCF determined that collateral contacts are acknowledged as part of the assessment and treatment components of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit for children under 21 enrolled in the Medicaid program. DHCF and the Department of Behavioral Health (DBH) met to determine the best regulatory pathway for payment of such services. Due to some other avenues that are allowable through DBH as described below, DHCF and DBH continue to consider whether Medicaid reimbursement is needed for behavioral health providers to bill for collateral contacts for all beneficiaries.

For beneficiaries under 21 with serious and persistent mental illness and those with a serious emotional disturbance who receive the Mental Health and Rehabilitative Services (MHRS) benefit, Medicaid does allow behavioral health providers to bill collateral contacts for community support if they are provided in person. While collateral contacts are not necessarily covered as a stand-alone service within DBH services, they are included in billing for Community Support and Community-Based Intervention (CBI) Services. Any expansion of collateral contacts to other MHRS services would require a Medicaid State Plan Amendment.

Over the past few years, DHCF and DBH have implemented new initiatives to improve access to behavioral health services for children enrolled in Medicaid. DHCF's Division of Children's Health Services (DCHS) serves on the DC Collaborative for Mental Health in Pediatric Primary Care to promote mental health screenings in pediatric primary care, and monitors data on mental health and developmental screenings. In addition, DCHS staff participate in early childhood and school-based mental health efforts with DBH and OSSE, and coordinate with DC MAP (Mental Health Access in Pediatrics), a DBH-funded program to provide assistance to pediatric primary care providers who need mental health consultation for a beneficiary during a well-child visit. In 2017, DHCF implemented My Health GPS to help Medicaid beneficiaries with three or more chronic conditions have a more coordinated approach to their health care needs. The My Health GPS model can connect the beneficiary with other types of services and incorporates a team approach (including behavioral health providers) to help get the services needed.