DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q1. Please provide the Committee with the following for FY21 and to date in FY22:

a. The number of full-time equivalents (FTEs) at each organizational level;
b. A list of all FY21 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 FY21 or to date in FY22.

Response:

a. Please see Attachment 1 to Q1for the current organizational chart along with the number of full-time equivalents (FTEs) at each organizational level.
b. Please see Attachment 2 to Q1 for FTEs broken down by program and activity along with the employee responsible for the management of each program/activity.
c. Please see the response above.
d. There were no organizational changes for FY21 or to date in FY22.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q2. Please provide the Committee with the following for FY21 and to date in FY22:

- **a. A list of all employees who received a 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 FY21 and to date in FY22 and the amount;**
- **c. A list of travel expenses for FY21 and to date in FY22, arranged by employee and**
- **d. A list of all employees with a salary over $100,000.**

Response:

a. Please see Attachment 1 to Q2 for the list of all employees who received a cell phone, personal digital assistants, or similar communication devices at agency expense.
b. There were no employees who received a bonus, special pay, additional compensation, or hiring incentive in FY21 and to date in FY22.
c. Please see Attachment 2(a) and (b) to Q2 for the list of travel expenses for FY21 and to date in FY22, arranged by employee.
d. Please see Attachment 3 to Q2 for the list of all employees with a salary over $100,000.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

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 "Attachment 1 to Q3" for reprogrammings received by and transferred from DHCF during FY21 and to date in FY22, including a description of the purpose of the transfer and which DHCF programs, activities, and services were affected.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q4. Please identify any intra-district transfers received by or transferred from DHCF during FY21 and to date in FY22 and include description as to the purpose of the transfer and which DHCF programs, activities, and services were affected.

Response:

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

Please note that the FY22 Amount column in the attachment is based on the amount budgeted and does not reflect the status of the transfer of funds nor the final intent of both agencies. Many of the Memorandums of Understanding (MOUs) are in process within both agencies and will be implemented during FY22.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q5. Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY21 and to date in FY22. 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 FY22; and**
- **e. FY21 and to date FY22 expenditure of funds, including purpose of expenditure.**

Response:

Please see "Attachment to Q5" for a complete accounting of DHCF's Special Purpose Revenue Funds for FY21 and to date in FY22.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q6. Please provide the following information for all grants awarded to DHCF during FY21 and to date in FY22:

- **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 "Attachment to Q6" for the information requested for all grants awarded to DHCF during FY21 and to date in FY22. The current fiscal year expenditures are through the first quarter, December 31, 2021.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q7. For each grant lapse that occurred in FY21, 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 FY22.

Response:

DHCF did not have any grant lapse in FY21. Please see "Attachment to Q7."

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q8. Please provide DHCF's capital budgets for FY21 and FY22 and include the following information:

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

Response:

Please see "Attachment to Q8" for DHCF's capital budgets for FY21 and FY22.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PEFORMANCE OVERSIGHT QUESTIONS

Q9. Please provide DHCF's fixed costs budget and actual dollars spent for FY21 and to date in FY22, 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 "Attachment to Q9" for DHCF's fixed cost budget and actual dollars spent for FY21 and to date in FY22, including source of funding. Please note that the FY22 allocation across funding sources has not been updated based on DHCF's cost allocation results. Once the accounting transaction is complete, local expenditures will not exceed the approved budget.

b. The DHCF budget has a year-over-year net decrease of $673,000 in budget authority. This decrease is mainly attributed to a reduction in rent at the L'Enfant Plaza offices. The rent was negotiated after the FY21 formulation, resulting in a surplus in rent of $717,000.

Based on anticipated cost, DHCF is expected to spend the full FY22 budget allocation for fixed cost.

c. The agency anticipates lower utility costs as a result of the continuing pandemic, which has required a large amount of the agency to work remotely. DHCF is also working with the Department of General Services (DGS) to ensure that location and cost for space allocation is accurate and up to date.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q10. Please provide the following information for all contracts awarded by DHCF during FY21 and to date in FY22, broken down by DHCF program and activity:

- **a. Contract number;**
- **b. Approved Budget Authority;**
- **c. Funding source;**
- **d. Whether it was competitively bid or sole sourced;**
- **e. Expenditures (including encumbrances and pre-encumbrances);**
- **f. Name of the vendor;**
- **g. Contract deliverables;**
- **h. Contract outcomes; and**
- **i. Date of contract expiration after option years.**

Response:

Please see "Q10 & Q11 Attachment 2" for information on DHCF contracts and contract modifications.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q11. Please provide the following information for all contract modifications made during FY21 and to date in FY22:

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

Response:

Please see "Q10 and Q11 Attachment 2" for information on DHCF contracts and contract modifications.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q12. Did DHCF meet the objectives set forth in the performance plan for FY21? For any performance indicators that were not met, please provide a narrative description of why they were not met, and the corrective actions taken.

Response:

Please see FY21 Performance Plan at Attachment 1 to Q12. The status of performance indicators is as follows:

- Five (5) Key Performance Indicators (KPIs) were met in FY21.
- Five (5) KPIs are awaiting data.
    - The data for the following two (2) KPIs will not be available until April 2022, when information is reported to the Centers for Medicare & Medicaid Services (CMS) in the CMS 416 report. The agency does not advise releasing the numbers until they are certified by CMS.
        - Percent of children, ages 1 - 20 years, enrolled in the Medicaid program (Fee-for-Service and Managed Care) with 90 days of continuous enrollment that received preventive dental services during the fiscal year.
        - Percent of children, ages 1 - 20 years, enrolled in the Medicaid program (Fee-for-Service and Managed Care) with 90 days of continuous enrollment that received a routine well-child examination during the fiscal year.
    - The data for the following three (3) KPIs will not be available until March 2022, because a run-out period of claims data over six months is necessary to collect and calculate the outcomes and lag-times in provider and facility billing.
        - Reduce hospital discharges of Medicaid Managed Care enrollees that were followed by a readmission for any diagnosis within 30 days.
        - Reduce potentially preventable Emergency Department visits by Medicaid Managed Care enrollees that may have been avoided or appropriately treated at a lower level of care.
        - Reduce hospital admissions of Medicaid Managed Care enrollees due to health conditions that may have been prevented through appropriate outpatient care.

- The data for five (5) new KPIs added in FY21, are not available. They are reflected as "New in 2021" within the agency's FY21 Performance Accountability Report (PAR).

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q13. What are DHCF's performance objectives for FY22?

Response:

Please see "Attachment to Q13" for DHCF's FY22 Performance Plan.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q14. Identify each District of Columbia agency that submitted Medicaid claims in FY21 andFY22, to date, and include the following information:

a. **The number and total dollar amount of claims filed per agency eachmonth;**
b. **The number and total dollar amount of claims denied per agency eachmonth, 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 theASO.**

Responses:

(a) and (b) Please see the attachment to Q14 for the total dollar amount of claims filed and denied per agency each month.

Based on FY21–22, to date, the most common reasons for denials were:

- Exact duplicate claim,
- Ineligible program code,
- Service covered by MCO,
- Beneficiary not eligible/not found, and
- Beneficiary name mismatch.

(c) The billing agents used by each of the agencies that conducted claiming to DC Medicaid as exhibited in Attachment 1 are as follows:

Agency	**Billing Agent**
DC Public Chartered Schools (DCPCS)	ASO
Office of the State Superintendent (OSSE)	ASO
DC Public Schools (DCPS)	ASO
Child & Family Services (CFSA)	ASO
St. Elizabeth's Hospital & Dental Clinic	Within agency
DC Behavioral Health (DBH)	Within agency
DC Fire Department & Ambulance Services (FEMS)	Change Health Care

(d) 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.

Currently, there are no new opportunities for integration of other District agencies into the ASO, for 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

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q15. Please provide copies of any investigations, reviews, or program/fiscal audits completed on programs and activities within DHCF during FY21 and to date in FY22, 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****:* 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.

   This cycle reviewed Medicaid and CHIP payments made in Reporting Year (RY) 2021 (July 1, 2019 through June 30, 2020). The RY 2021 improper payment rates are reported in the Agency Financial Report[1] (AFR) published in November 2021. Additional details are available at: Cycle 3 | CMS[2] and PERM Error Rate Findings and Reports | CMS[3].

   In response to the 2017 PERM, DHCF recouped overpaid funds from providers and required each provider to conduct training regarding documentation requirements, including testing and the submission of a Corrective Action Plan (CAP) to ensure compliance and prevent the errors from recurring. DHCF is in the process of conducting a root cause analysis of the eight errors identified in the RY 2021 PERM and drafting a CAP to submit to CMS addressing the PERM findings.

2. ***CMS Financial Management Review***: In November 2020, CMS conducted a desk audit/virtual financial management review of DC's VIII Group Newly Eligible Population. The purpose of the review was to determine whether DHCF claims for reimbursement of Medicaid Eligible Expenditures comply with Federal and State requirements. DHCF made available to CMS a claims file consisting of roughly 1.7 million records (claims) submitted by Medicaid providers, and CMS conducted a random sample of 100 of those claims for review. As of this date, CMS has completed the field work but has yet to issue formal findings. DHCF is awaiting a final Audit Report detailing CMS' findings.

[1] https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf
[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Cycle_3
[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/PERMErrorRateFindingsandReport

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q16. Please identify each incident of Medicaid abuse or fraud investigated in FY21 and to date in FY22 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 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 to these roles, 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.

By the end of FY21, DHCF investigated or continued to investigate 182 cases of alleged Medicaid fraud. Of those cases investigated, 15 were referred to law enforcement. As of December 31, 2021, DHCF investigated or continues to investigate seven additional cases of alleged Medicaid fraud (i.e., a total of 182 cases investigated or continuing to be investigated across FY21 and FY22, to date). Please refer to Table 1 in the attachment for Q16 for more details on the investigative cases.

Based on preliminary investigations, whether ongoing or having 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:

- Behavioral health services claims with excessive units of service and services not provided;
- Community Service Workers related claims involving services not provided;
- Personal Care Services, including Personal Care Aides and Participant Directed Workers related claims with excessive units of services billed, services not provided, and kickback payments;
- 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;
- Physician services fraud;
- Pharmacy claims involving prescription fraud, specifically billing for 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, including the Medicaid Fraud Control Unit (MFCU), when applicable. Federal regulation 42 CFR § 455.23 requires that the State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

Please See Attached Document Containing the Following Tables:

- Table 1: Investigative Details
- Table 2: Audit Details

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PEFORMANCE OVERSIGHT QUESTIONS

17. 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 FY21 and FY22, to date, regarding:

a. Services provided and eligibility requirements in FY21 or FY22; and
b. Reimbursement rates/methodologies in FY21 or FY22.

Response:

a. Services provided and eligibility requirements in FY21 or FY22

- In FY21, 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), Immigrant Children's Program (ICP) and the DC Healthcare Alliance (Alliance). Through this solicitation, DHCF introduced an expanded service category for coverage and administration of behavioral health (BH) services to eligible populations.

  The new contract is intended to cover up to a 10-year period consisting of a five-year base period and a five-year option period. Implementation of BH services will begin in FY23, during the third year of the base period. Staff from the Department of Behavioral Health (DBH) and DHCF have partnered to conduct training and sessions necessary to ensure readiness by BH providers, contracted MCOs, and other entities critical to the integration of BH services into managed care.

  The new 10-year contracts are anticipated for award in the Summer of 2022.

- Beginning in FY22, emergency medical transportation (EMT) services are carved-out or excluded from the MCOs' scope of coverage for individuals enrolled in the DCHFP, including the ICP and Alliance. Rather than the services being reimbursed by the MCOs, qualifying providers must submit claims for EMT services incurred by a Medicaid, Alliance, or ICP enrollee to the DHCF for payment.

  This same action also becomes effective with the Child and Adolescent Supplemental Security Income Program (CASSIP) at the start of its new five-year contract period in FY22, which is described below.

- In FY21, OCP issued a solicitation to contract with an MCO to administer CASSIP. The five-year contract will be awarded to a single MCO to provide healthcare services to children and young adults who are voluntarily enrolled in the program.

- In FY22, DHCF's contracted Quality Improvement Organization (QIO), Comagine, will review and make determinations on referrals received for consideration of DCHFP

enrollees into CASSIP. Referrals can be presented to Comagine by DC Medicaid-enrolled providers for children and adolescents with special health care needs that do not meet the Social Security Administration (SSA) or the DC Economic Security Administration (ESA) medical and income eligibility criteria.

Medicaid beneficiaries enrolled in the DCHFP, aged 0-20 years old, may seek enrollment into the CASSIP based on a qualified disability, as determined by DHCF or Comagine. Comagine will use criteria defined by DHCF and aligned with the SSA's definition of a qualifying disability. Providers will be trained on the electronic submission process and all referrals will be reviewed by a physician, Registered Nurse, or Nurse Practitioner. All requests for which a "denial" is initially indicated must undergo a second level of review by a physician for final determination.

Other FFS and managed care eligibility and service changes include:

- Pharmacy
    - Beginning January 2022, COVID-19 home test kits are carved-out or excluded from reimbursement by the MCOs. Claims can be processed at point of sale through the FFS Medicaid Pharmacy Benefit Manager. However, managed care enrollees, including those enrolled in Alliance, may also receive out-of-pocket reimbursement with proof of purchase of a home test kit. This action complies with new regulatory guidance from the Centers for Medicare and Medicaid Services (CMS). It also helps eliminate confusion with the reimbursement process, while providing equitable care and access across the Medicaid and Alliance programs.

- Dental
    - As of March 10, 2021, Quality Plan Administrators (QPA) no longer serves as a Dental Benefit Administrator for FFS Medicaid beneficiaries. The service transitioned to DHCF's QIO contractor, Comagine.

    - The Current Dental Terminology (CDT) code for Molecular testing for a public health related pathogen, including coronavirus was added to the fee schedule for FY22.

    - The CDT code for Oral sleep apnea appliances that are prescribed by a sleep medicine physician was added to the fee schedule for FY22.

- Non-Emergency Medical Transportation (NEMT)
    - In FY22, DHCF will extend the vehicle requirement age limits for the medical transportation management provider network through December 31, 2022. The current age limit is eight years old for Paralift (wheelchair) and 10 years old for ambulatory vehicles. This extension will allow network providers to utilize their ambulatory vehicles (model year 2011) and wheelchair vehicles (model year 2013) to transport DC Medicaid beneficiaries until December 2022.

- Hospitals and Nursing Homes

  - In FY21 and FY22, DHCF relaxed the prior authorization process for inpatient general hospitals. This action was implemented temporarily for direct admissions and hospital to hospital transfers.

- In FY21 and FY22, DHCF temporarily suspended the requirement for out-of-state nursing home placements to allow timeliness in hospital discharges.

- In FY21 and FY22, DHCF updated the organ transplantation list to include living donor kidney and liver transplants for all Medicaid beneficiaries.

b. Reimbursement rates/methodologies in FY21 or FY22

- Risk-Corridor
  - In FY22, DHCF will implement Risk Corridors as a mechanism to minimize unanticipated losses by MCOs due to disproportionate shares of enrollment and higher costs of care for DCHFP, Alliance, and ICP Enrollees. The MCOs, through award of a new 10-year contract via the current pending solicitation, agree to enter into a risk-sharing arrangement to limit the financial gains and losses for the risk-based contract.

    The risk corridor will be effective for the base period of the contract, with potential annual updates to the financial parameters of the risk corridor. The continuation of the risk corridor will be reassessed for the option period of the contract. Separate risk corridors will apply to the DCHFP and Alliance programs.

- Beginning in FY22, the MCOs will reimburse District hospitals a minimum of 100% of the Medicaid APR-DRG fee schedule for services provided to DCHFP enrollees only. Outpatient services will be reimbursed at no less than 100% of the DC Medicaid EAPG rate methodology for services provided to DCHFP enrollees only. These provisions do not apply to Alliance and ICP enrollees.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

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 "Attachment to Q18" for enrollment statistics by 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]

Please see the response to Question 19 for expenditure-related information to the various programs under both FFS and MCO populations during FY21 and the first quarter of FY22. DHCF is currently in the process of reforecasting the FY22 anticipated expenditures for Provider Payments as a result of changes that occur due to the public health emergency and will have that available in the next Financial Review Process (FRP) submission (based on actuals through January 2022 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.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

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 FY21 and to date in FY22.

Response:

Please see "Attachment to Q19" for a service level breakout of expenditures. The FY22 expenditures are through December 31, 2021.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q20. For each waiver program, please provide a description of and reason for any changes or planned changes in FY21 and FY22, to date, and:

a. FY22 Enrollment, 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:

Please refer to the response to Question #19 for aggregated budget and spending information for FY21 and the first quarter of FY22 for both the Elderly and Persons with Physical Disabilities (EPD) and Individuals with Intellectual and Developmental Disabilities (IDD) Waivers. These data are aggregated and reflect total utilization, although expenditures and utilization per enrollee are not included.

Please see "Attachment 1 to Q20" for FY21 and FY22, to date, for enrollment by gender for the (EPD) Waiver, and "Attachment 2to Q20" for FY21 and FY22, to date, for enrollment by gender for the (IDD) Waiver.

Please note that FY22 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.

a. ***IDD Waiver***: The IDD Waiver has a capacity of 1,903 for Waiver Year 4 (November 20, 2021 through November 19, 2022). As of January 31, 2022, 1,867 individuals were enrolled in the IDD Waiver. There is no waiting list.

Individual and Family Supports (IFS) Waiver: The capacity for the IFS waiver is 60 for Waiver Year 2 (November 1, 2021 through October 31, 2022). This waiver has four enrollees as of January 31, 2022.

EPD Waiver: The enrollment cap for the number of unduplicated participants in Waiver Year 5 (April 4, 2021 through April 3, 2022) is 5,560 and for the first year of the proposed waiver renewal, the cap is 6,060. The enrollment is 5,066 as of January 31, 2022. There is no waiting list at present.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q21: Please provide a list of all State Plan Amendments (SPAs) or demonstration projects submitted to CMS for approval in FY21 or planned for submission in FY22 and FY23. 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: FY21 and FY22 SPA/Waivers Submitted to CMS for approval (as of January 25, 2022)

TN	SPA/Waiver	Description	Status	Service Change	Cost/Savings
20-0007	Adult Substance Use Rehabilitation Services Reimbursement	Increases reimbursement to ASARS providers to support additional costs related to the delivery of services during the COVID-19 public health emergency.	Submitted: 8.25.20 Approved: 10.6.20 Effective: 3.1.20	N/A	FY20: $813,000.00 FY21: $0
20-0008	Living Donor Transplant Services	Permits the District of Columbia Medicaid Program to cover transplantation of a kidney or liver from a living donor and related care provided to that living donor.	Submitted: 12.22.20 Approved: 5.27.21 Effective: 4.1.21	Allows coverage for services provided to a living donor, who donates a kidney or living to a Medicaid beneficiary, who would not otherwise be eligible for Medicaid coverage.	FY21: $68,000 FY22: $117,000
20-0009	Adult Day Health Program Reimbursement	Provides an inflation increase to Adult Day Health Program 1915(i) payment rates.	Submitted: 12.22.21 Approved: 3.17.21 Effective: 1.4.21	N/A	FY21: $209,000 FY22: $311,000
20-0010	Integrated Multi-Benefit Paper Application	Approves the new, integrated application to allow individuals to apply for medical, food, and/or cash benefits in the District in one application. The integrated application aligns with the District's integrated eligibility system launched in 2021.	Submitted: 12.29.20 Approved: 5.6.21 Effective: 7.1.21	N/A	FY21: $0 FY22: $0

Table 1: FY21 and FY22 SPA/Waivers Submitted to CMS for approval (as of January 25, 2022)

TN	SPA/Waiver	Description	Status	Service Change	Cost/Savings
21-0001	Physician Supplemental Payment	Continues a physician supplemental payment for fiscal year 2021 to a group practice with at least five hundred (500) physicians that are members of the group. .	Submitted: 1.15.21 Approved: 4.12.21 Effective: 1.1.21	N/A	FY21: $3,429,000
21-0002	Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Direct Support Professional (DSP) Supplemental Payment	Refocuses the objectives of the Stevie Sellows assessment and supplemental payments, by focusing supplemental payments specifically on reimbursing ICF/IIDs for DSP wages and training expenses to ensure DSPs are paid a competitive wage.	Submitted: 3.4.21 Approved: 5.7.21 Effective: 4.1.21	N/A	FY21: $1,271,940 FY22: $1,820,000
21-0003	ICF/IID DSP Supplemental Payment	Provides ICF/IID providers with a supplemental payment for Direct Service Provider wages for the January 1, 2021 to March 31, 2021 period.	Submitted: 3.4.21 Approved: 5.7.21 Effective: 1.1.21	N/A	FY21: $662,940 FY22: $0
21-0004	Medication Assisted Treatment (MAT) for Opioid Use Disorders (OUD)	Effective October 1, 2020, permits the District to provide MAT for OUD as a mandatory state plan benefit in compliance with section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).	Submitted: 3.26.21 Approved: 6.7.21 Effective: 10.1.20	Covers as a mandatory benefit all FDA approved MAT drugs, FDA licensed MAT biological products, and MAT behavioral counseling and therapy services.	FY21: $0 FY22: $0
21-0005	Outpatient Hospital Supplement Payment Fiscal Year 2021	Sunsets outpatient hospital supplement payment, effective January 8, 2021, instead of September 30, 2029.	Submitted: 3.31.21 Approved: 10.19.21 Effective: 1.9.21	N/A	FY21: $4,075,000 FY22: $4,075,000
21-0006	Recovery Audit Contractor Waiver	Effective June 1, 2021 until expiration on May 31, 2023, this amendment waives the requirement that Medicaid agencies contract with a recovery audit contractor, which identifies and corrects improper Medicaid payments through the collection of overpayments and reimbursement of underpayments made on claims for health care services provided to Medicaid beneficiaries..	Submitted: Approved: 4.29.21 Effective: 6.1.21	N/A	FY21: $0 FY22: $0

Table 1: FY21 and FY22 SPA/Waivers Submitted to CMS for approval (as of January 25, 2022)

TN	SPA/Waiver	Description	Status	Service Change	Cost/Savings
21-0007	COVID-19 Vaccine Administration Reimbursement	Permits the District to increase reimbursement to Medicaid providers to one hundred percent (100%) of the rates paid by the Medicare program and clarifies that COVID-19 vaccine administration may be reimbursed to the administering provider, but not the nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID), where the procedure is provided to a Medicaid enrolled individual.	Submitted: 6.23.21 Approved: Under Review Effective: 12.11.20	N/A	FY21: $6,794,853 FY22: $8,262,453
21-0008	Online Integrated Application	Approves the new integrated application to allow individuals to apply online for medical, food, and/or cash benefits in one application. The integrated application aligns with the District's new integrated eligibility system which launched in 2021.	Submitted: Approved: Under Review Effective: 9.27.21	N/A	FY21: $0 FY22: $0
21-0009	Behavioral Health Services/Other Licensed Providers	Permits the District to enroll additional licensed providers (psychologists, licensed independent clinical social workers, licensed professional counselors and licensed marriage and family therapists) to service the District's Behavioral Health population. Additionally, under the SPA authority for behavioral health services, removes the Autism Spectrum Disorder (ASD) treatment exclusion.	Submitted: 6.30.21 Approved: 9.24.21 Effective: 1.1.22	Removes restriction on provision of services for Autism Spectrum Disorder	FY21: $1,669,313 FY22: $2,321,458
21-0010	Mental Health Rehabilitative Services (MHRS)/Adult Substance Use Rehabilitative Services (ASURS)/Behavioral Health Stabilization/Transition Planning Services	Transitions MHRS, ASURS and Behavioral Health Stabilization services from the District's Behavioral Health 1115 Demonstration and establishes Transition Planning Services under the Medicaid State Plan.	Submitted: 6.30.21 Approved: Under Review Effective: 1.1.22	Provides certain behavioral health services under the State Plan.	FY22: $4,953,116 FY23: $6,999,133

Table 1: FY21 and FY22 SPA/Waivers Submitted to CMS for approval (as of January 25, 2022)

TN	SPA/Waiver	Description	Status	Service Change	Cost/Savings
21-0011	Supported Employment Services for Serious Mental Illness/Substance Use Disorder	Permits the District to establish the process for participation in Supported Employment Services for qualified individuals who either have a serious mental illness or substance use disorder.	Submitted: 6.30.21 Approved: Under Review Effective:1.1.22	Establishes a new service under State Plan.	FY21: $310,219 FY22: $431,412
21-0012	Pediatric Vaccines	Permits the District to reimburse for pediatric vaccines and their administration by participating fee-for-service pharmacy providers.	Submitted: 8.4.21 Withdrawn: 9.17.21 Effective: N/A	N/A	FY21: $2,552,000
21-0013	Home Health Services	Increases the Home Health Service rates.	Submitted: 9.20.21 Approved: 10.27.21 Effective: 7.1.21	N/A	FY21: $725 FY22: $2,900
21-0014	Adult Day Health Program (ADHP)	Incorporates the District's Dual Eligible Special Needs Plans into the ADHP.	Submitted:10.1.21 Approved: Under Review Effective: 2.1.22	N/A	FY22: $0 FY23: $0
21-0015	Housing Supportive Services	Permits the District to provide housing supportive services (HSS) via 1915(i) state plan Home and Community Based Services. Supportive services include housing-related activities and services for obtaining and sustaining stable housing, such as case management.	Submitted: 9.30.21 Approved: Under Review Effective: 4.1.22	Establishes a new service under the State Plan.	FY22: $17,585,367 FY23: $35,170,734
21-0016	Physician Supplemental Payment	Continues a physician supplemental payment for FY22 to a group practice with at least five hundred (500) physicians that are members of the group.	Submitted: 10.1.21. Approved: 11.23.21 Effective: 10.1.21	N/A	FY22: $4,5000,000
21-0017	1932(a) Managed Care/Children and Adolescents for Supplemental Security Income Program (CASSIP)	Authorizes the District's Medicaid program to continue to allow individuals who are receiving supplemental security income, are age twenty-one or older, and are currently enrolled in the CASSIP program to voluntarily remain enrolled in CASSIP until age twenty-six.	Submitted: 10.1.21 Approved: 11.9.21 Effective: 10.1.21	N/A	FY22: $0 FY23: $0

Table 1: FY21 and FY22 SPA/Waivers Submitted to CMS for approval (as of January 25, 2022)

TN	SPA/Waiver	Description	Status	Service Change	Cost/Savings
21-0018	Non-Emergency Medical Transportation (NEMT)	Provides assurances to comply with federal non-emergency medical transportation requirements, as required by the Consolidated Appropriations Act, 2021 (Public Law 116-260).	Submitted: 12.15.21 Approved: Under Review Effective: 12.27.21	N/A	FY22: $0 FY23: $0
21-0019	Third Party Liability (TPL) Payment of Claims	Provides assurances to comply with TPL requirements under the Bipartisan Budget Act of 2018 and the Medicaid Services Investment and Accountability Act of 2019.	Submitted: 12.23.21 Approved: Under Review Effective: 12.31.21	N/A	FY22: $0 FY23: $0
21-0020	Federally Qualified Health Centers (FQHC) Rate Rebasing	Delays rebasing of FQHC rates, by one calendar year, due to the COVID-19 public health emergency.	Submitted: 12.23.21 Approved: Under Review Effective: 1.1.21	N/A	FY21: $0 FY22: $0
21-0021	Disproportionate Share Hospital (DSH) Payment	Permits the District of Columbia to establish a new category of disproportionate share hospitals and implement updated payment standards for the newly created class effective October 1, 2021.	Submitted: 12.23.21 Approved: Under Review Effective: 10.1.21	N/A	FY22: $9,4000,000 FY23: $9,200,000
DC.0334. R05.00	DC Elderly and Persons with Disabilities (EPD) 1915(c) Waiver	Renews the District's EPD Waiver and incorporates Dual Eligible Special Needs Plans.	Submitted: 10.1.21 Approved: Under Review Effective: 2.1.22	N/A	FY22: $248,204,619 FY23: $315,747,914

Table 2: FY22 and FY23 Anticipated SPA/Waiver Submission

SPA/Waiver	Description
Burial Funds/Excess Resource Financial Eligibility	Proposes changes to the State Plan and District of Columbia Municipal Regulations (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.
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 B24-0143, the "Certified Professional Midwife Amendment Act of 2021" by providing for the enrollment and reimbursement of licensed certified professional midwives.
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.
Physician Supplemental Payments	Provides a supplemental payment in FY 23 to eligible an eligible group practice with at least five hundred (500) physicians that are members of the group.
Routine Care in Connection with Clinical Trials	Complies with Centers for Medicare and Medicaid State Medicaid Director Letter #21-005 which outlines new Medicaid state plan requirements for assuring coverage of routine patient costs associated with participation in qualifying clinical trials. The District already complies with the requirements in practice, so only a State Plan Amendment is required.
Doula Services	Complies with the Fiscal Year 2022 Budget Support Act of 2021 (BSA) requirement that DHCF cover doula services in Medicaid, the D.C. HealthCare Alliance Program (Alliance), and Immigrant Children's Program (ICP) effective October 1, 2022. DC Health is required to certify doulas so they can provide services.
Postpartum Coverage Extension	Extends the coverage for postpartum services for pregnant women from 60 days after the end of the pregnancy to 12 months after the end of the pregnancy.
EPSDT Pediatric Vaccine Counseling	To provide coverage and reimbursement for stand-alone vaccine counseling visits as part of vaccine administration required for all pediatric vaccines under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).
Pharmacy	To extend the time for which a Medicaid beneficiary must file a request for a hearing for an adverse pharmacy determination with the Office of Administrative Hearings (OAH) from 15 days to 90 days.
Autism Spectrum Disorder (ASD)	Establishes the covered and reimbursable services for ASD treatment as well as behavioral health providers in the District authorized to provide ASD services.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

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.

Response:

Table 1 below reflects which delivery system in which the PRTF beneficiary is served at the time of placement. Each Medicaid Managed Care Organization (MCO) is specified in the table below. There was a total of 26 Medicaid beneficiaries placed at a PRTF in FY21**.**

Table 1. PRTF Beneficiaries Served:

Delivery Management System	Beneficiaries Served	Percent of Total
Fee-for-Service	16	61.5%
AmeriHealth Caritas DC	8	30.8%
Medstar Family Choice	0	0
CareFirst Community Health Plan/DC	0	7.7%
Continued Stay	2	0
Total	**26**	**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. Although the majority of youth that meet the medical necessity threshold are placed within that timeframe, there are instances in which they might be placed outside of the 60 days. Reasons for a delay in placement include:

- Youth has absconded;
- Delayed approval of the Interstate Compact on the Placement of Children (ICPC); and
- PRTF placement difficult due to symptomatology.

Table 2 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	1
Florida	4
Georgia	5
Indiana	2
Pennsylvania	2
Arizona	1
Virginia	11

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, generally the average length of stay in a PRTF is six months (180 days).

Sister Agency Involvement

As noted earlier, DBH is responsible for certifying medical necessity for the PRTF level of care for placements to be funded by Fee-for-Service Medicaid. In June of FY21, a prior authorization requirement was put in place for PRTF care paid for by Fee-for-Service (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 (see Table 3 below) and approved by the Review Committee, the recommending 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. In every case, DHCF will work with its full-risk MCOs, including AmeriHealth Caritas DC, MedStar Family Choice, CareFirst Community Health Plan of DC, and DBH to facilitate the smooth transfer of monitoring responsibilities for youth moving from Managed Care to FFS Medicaid in their placements. 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 is based on information from DBH regarding which sister agency has placed the youth. If the youth is not affiliated with the Children and Family Services Agency (CFSA), the Department of Youth Rehabilitation Services (DYRS), or Child Support Services (CSS), DBH has primary responsibility for monitoring.

Table 3. Beneficiaries Placed at a PRTF by Sister Agencies:

Agency	Number of Beneficiaries
Child and Family Services (CFSA)	3
District of Columbia Public School (DCPS)	1
Department of Youth Rehabilitation Services (DYRS)	0
Department of Behavior Health (DBH)	16
DC Superior Court	6
Office of the State Superintendent of Education (OSSE)	0

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

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.

Response:

Salazar[1] is a long-running consent decree case, originally filed in 1993, 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[2]; (4) adequate advance notice of termination from Medicaid benefits during annual renewal[3]; and (5) reimbursement of eligible out-of-pocket expenditures. The single remaining claim involves service delivery of the EPSDT benefit to children enrolled in Medicaid. The case is aggressively litigated, resulting in numerous additional court orders which 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, alleging 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 2021, the District submitted all required reports to the Court. As for the measures, while the District consistently has met or was above the national average for utilization measures for well-child visits and dental services, the District's utilization performance continues to remain below the target required by the 1999 Settlement Order and the 2003 Dental Order. Further, the COVID-19 pandemic continues to negatively affect utilization measures nationally and in the District.

DHCF, through its own efforts and in working with managed care organizations (MCOs), providers, and sister agencies, strives to increase utilization of preventive care and encourages families to take their children to the doctor for well-child visits. The national average for children ages 0-20 years old receiving well-child visits in FY20 is unavailable, while the District reported a utilization rate of 50%. In addition, prior to the COVID-19 pandemic, the District was above or close to the national average for all age categories specified in the Centers for Medicare and Medicaid Services (CMS) Form 416 (Annual EPSDT Participation Report).

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

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[1] *Salazar v. District of Columbia*, Civil Action No. 93-452 (TSC).
[2] Provisions relating to the third category were dismissed by consent in 2009 after the parties agreed that the Districthad satisfied the exit criteria.
[3] provisions relating to the fourth category were dismissed by Court order in 2013 because those requirementsconflicted with the Affordable Care Act (ACA).

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% of Medicaid-enrolled children aged 3-20 years old receive any dental visit. The latest data shows that 47% of DC Medicaid children aged 3-20 years old received any dental visit in FY20.

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. Further, DHCF is enlisting the help of primary care providers to encourage parents to seek early oral health care 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 seventh 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 receiving fluoride varnish applications and/or oral health assessments during their well-child visit in FY20 was 16% (from 5% in FY16).

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

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q24. For the Alliance program, please provide data on the percentage of terminations each year since requirement has been in place.

Response:

For the purposes of this response, DHCF is assuming the reference to "requirement" is the six-month recertification requirement. DHCF implemented the six-month, face-to-face recertification process in October 2011. The intention of the six-month, face-to-face recertification requirement in the Alliance program was to increase accountability for District residency and deter non-resident enrollment. Since this requirement was implemented, the annual percentage of terminations of enrollment for Alliance beneficiaries who did not re-enroll within one year has ranged from a high of 29% in the first year of implementation (FY2012) to a low of 1% in FY2022 due to continuity of coverage requirements for the COVID public health emergency. Due to the public health emergency beginning 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. As a result, the number of Alliance enrollees who had their coverage terminated in FY2020, FY2021, and FY2022 was significantly lower compared to prior years. In the preceding years prior to FY2020, the annualnet termination percentage was approximately 20%.

The table below provides beneficiary information for each Fiscal Year between 2012 and 2022 to date:

DC Alliance Enrollment Analysis, FY 2012-FY 2022 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	29,114	12,736	3,675	598	8,463 (29%)
2013	21,963	8,412	3,168	316	4,928 (22%)
2014	21,115	7,225	2,830	250	4,145 (20%)
2015	21,926	7,687	2,981	277	4,429 (20%)
2016	22,026	7,956	2,820	351	4,785 (22%)
2017	22,187	7,742	2,905	181	4,656 (21%)
2018	21,469	7,759	3,012	148	4,599 (21%)
2019	21,179	7,312	2,888	136	4,288 (20%)
2020	20,368	3,346	934	60	2,352 (12%)

2021	22,299	456	18	1	437 (2%)
2022 YTD	22,681	118	2	0	116 (1%)

***Source:** DHCF Medicaid Management Information System (MMIS) data extracted January 21, 2022.

***Notes:** Beneficiaries who disenrolled from the Alliance program, but immediately enrolled in theMedicaid program were not included in the count of terminated beneficiaries. The number of Alliance enrollees who had their coverage terminated in FY 2020, FY 2021, and FY 2022 was significantly lower compared to prior years because coverage was automatically extended to enrollees during the public healthemergency.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q26. Regarding renewal notices:

a. **Of Medicaid enrollees who have been required to renew manually in FY22 to date, how many received pre-populated renewal forms no later than 60 days prior to the end of their certification period?**
b. **Please describe any problems the Department is encountering in sending notices to Medicaid recipients.**

Responses:

DHCF has suspended all Medicaid renewals for the duration of the federal public health emergency, which began in FY2020. Thus, no responsive data can be produced on this issue.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q27. For Medicaid enrollees required to renew manually in FY22 to date, please provide (preferably broken out by month):

a. The number and percentage of households in (1)(c) who returned renewal forms prior to the end of their certification period.
b. The number and percentage of households in (1)(c) who were terminated for failure to manually renew prior to end of their certification period.
c. The number and percentage of households in (2)(b) who lost coverage at the end of their certification period but were able to regain coverage during the 90-day grace period following the end of their certification period.
d. For enrollees who were terminated but manually renewed during the grace period, please provide:
    i. The average number of days enrollees were without coverage.
    ii. The number of enrollees who were without coverage for:
        a. 30 days or less
        b. 31 to 60 days
        c. Longer than 60 days
e. The number and percentage of households in (2)(b) who lost coverage at the end of their certification period and were *not* able to regain coverage within the 90-day grace period following the end of their certification period.

Responses:

DHCF has suspended all Medicaid renewals for the duration of the federal public health emergency, which began in FY2020. As such, no responsive data can be produced on this issue.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q28. Regarding renewal notices:

a. **Of Medicaid enrollees who have been required to renew manually in FY22 to date, how many received pre-populated renewal forms no later than 60 days prior to the end of their certification period?**
b. **Please describe any problems the Department is encountering in sending notices to Medicaid recipients.**

Responses:

DHCF has suspended all Medicaid renewals for the duration of the federal public health emergency, which began in FY2020. Thus, no responsive data can be produced on this issue.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q29. Please describe the agency's plan for informing the public about the roll back of PHE protections, including timeline, method of communication (e.g., print, media, social media), language access, and target populations or wards.

Response:

DHCF is currently developing a communication strategy for the end of the federal public health emergency (PHE) and plans to hire a communications vendor to help with additional approaches and implementation. The plan will include stakeholder engagement with providers, facilities, managed care organizations (MCOs), and other community advocates. Methods of communication will include social media, print fliers, a potential one stop website with information, mail, calls, texts, and push notifications through the new District Direct app. The outreach campaign will be released in English, Spanish, and Amharic, along with all other languages required by the DC Office of Human Rights to ensure compliance. The campaign will target all Medicaid beneficiaries in the District.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q30. How did DHCF address potential Medicaid terminations as the Public Health Emergency (PHE) protections were rolled back?

a. Has the Department sent or will it be sending everyone currently enrolled a letter informing them of the redetermination process? When?

Response:

The federal Public Health Emergency is still in effect and Medicaid terminations protections have not been rolled back. DHCF is awaiting guidance from Centers for Medicare and Medicaid Services (CMS) on the date of the end of the federal PHE.

DHCF will send communications to all current Medicaid beneficiaries once the agency receives notice from CMS of the end date of the federal PHE. Additionally, DHCF plans to send a notice with renewal information at least at least 60 days prior to the end of the beneficiary's recertification end date under MAGI Medicaid and 90 days for non-MAGI beneficiaries. The renewals are issued monthly based on recertification end date.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q31. If not for the PHE protections, how many households would have been terminated from Medicaid?

Response:

DHCF estimates that approximately 11,804 beneficiaries would have been terminated if not for the protections afforded by the public health emergency (PHE).

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q32. Can DHCF provide a list and description of Medicaid protections put in place during the PHE and a timeline of when these protections ended or are anticipated to end?

Response:

DHCF implemented multiple protections during the PHE, initially declared on March 11, 2020, for its beneficiaries, along with the continuous coverage provisions that ended at the conclusion of the PHE. The full list is available in the document "Attachment to Q32".

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q33. Regarding post-PHE redeterminations:

a. **How long does the Department plan to take to make redeterminations?**
b. **What, if any, staffing changes has the Department implemented or does it intend to implement to make redeterminations (e.g., increase staffing, overtime)?**
c. **Has the Department readjusted recertification periods to more evenly spread workload for future years? Does it plan to?**
d. **Has the Department readjusted recertification periods to put participants in the same household together? Does it plan to?**
e. **Does the Department have an estimate of how many people are or will be ineligible after redetermination?**

Responses:

a. DHCF plans to use the full 12-month period provided by the Centers for Medicare and Medicaid Services (CMS) guidance. This will prevent a frontload of work for eligibility workers.
b. DHCF is currently conducting internal discussions about hiring an additional staff member to help with redeterminations after the public health emergency (PHE).
c. DHCF has not readjusted recertification periods. Throughout the PHE, DHCF has extended renewals on a rolling basis, allowing for a more streamlined restart effort that will prevent frontload after the end of the federal PHE.
d. DHCF has not readjusted recertification periods; there are no changes that the agency can make without the beneficiary stating a change of household.
e. DHCF does not have a current estimate since the number of beneficiaries continues to grow, and the U.S. Department of Health and Human Services (HHS) has extended the PHE. CMS guidance also requires all beneficiaries to be redetermined after the PHE.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q34. What steps is the agency taking to consider all bases of eligibility prior to making a determination of ineligibility? [*See* 42 C.F.R. s. 435.912(f)(1)]

a. **What is in place to ensure that MAGI beneficiaries get fully screened for non-MAGI categories, including disability-based categories?**
b. **What is in place to trigger the system to screen for disability-based categories, especially those for former recipients of SSI?**
c. **What, if any, additional procedures are being used prior to making a determination of ineligibility for non-MAGI beneficiaries?**

Responses:

DHCF implemented District Direct on November 15, 2021, an integrated eligibility system that includes rules logic to automatically redetermine an individual for all categories.

a. As part of District Direct, a new integrated application was developed to evaluate an applicant for Medicaid coverage for all categories. If a MAGI beneficiary indicates disabled on the application, the individual completes the disability and non-MAGI related questions to determine eligibility for non-MAGI disability- based categories.
b. District Direct is automatically programmed with rules logic to identify when a beneficiary loses SSI coverage. Before Medicaid eligibility is terminated, the Medicaid beneficiary will be mailed a form to complete and return to the agency to be screened for Medicaid under a different category.
c. Prior to making a determination of ineligibility for non-MAGI beneficiaries, District Direct will send a notice with supplemental form to be completed and returned to the agency to be evaluated for Medicaid under another category like MAGI, LTCSS etc. The beneficiary has 15 days to return forms to complete a redetermination for coverage under another category prior to termination.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q35. Recognizing that so many folks have moved during the pandemic, how has the Department addressed returned mail?

a. **Has the Department or will the Department look at other data systems to identify current addresses? If so, which ones?**
b. **Has the Department or will the Department be working with MCOs or other entities to update addresses?**
c. **Has the Department or will the Department be doing anything to check and update addresses before beginning the redetermination?**

Responses:

DHCF has paused Medicaid redeterminations during the federal public health emergency (PHE), such that eligibility factors for many beneficiaries have not been verified or updated in over a year. This creates an obvious challenge since redeterminations will need to resume in large volumes following the conclusion of the PHE. While updated addresses will be available in any instance where a beneficiary has reported a change in address to the agency or utilized District Direct to renew SNAP/TANF benefits, we will be deploying staff to track returned mail and conduct outreach to those beneficiaries. DHCF will also rely on the Public Assistance Reporting Information System to determine whether a beneficiary has left the District and is receiving benefits in other states.

DHCF is reviewing the feasibility of utilizing additional data sources to identify current addresses for beneficiaries, including working with our partners at managed care organizations. However, there are federal restrictions on the sources of information that can be used/considered a primary source of information to update to eligibility address information. The District participates in ongoing discussions with the Center for Medicaid and Medicare Services (CMS) concerning unwinding from the PHE at large, which may include a discussion of using additional data sources to the extent CMS permits or authorizes.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q36. Does the Department have plans for enhanced/extra outreach to specific populations, e.g., limited English proficient (LEP) individuals, those who are medically frail, older people after a request for information or verifications is sent so that these populations receive the assistance they need? [*See* 42 U.S.C. s. 435.916, citing s. 435.905]

a. **Has or will the District be analyzing trends in procedural denials to determine if such populations are disproportionately terminated on procedural grounds?**
b. **Has or will the District take any action to help such individuals be re-enrolled within the 90-day reinstatement window?**

Responses:

DHCF plans to use its various partnerships within the advocate community and will also work closely with Federally Qualified Health Centers (FQHCs) and other providers to assist with reaching out to beneficiaries. DHCF will also coordinate outreach with our District sister agencies.

a. Yes, DHCF does plan to analyze trends for procedural denials.
b. DHCF plans to work with our Managed Care Plans to encourage beneficiaries to complete and submit recertifications prior to the end of their renewal period and during the 90-day reinstatement window.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

37. Has DHCF been making data available on a real-time basis showing renewal statistics?
   a. Is this data separated by category of eligibility?
   b. Has the Department analyzed data looking for trends of terminations? Is the Department planning to do any quality control or other auditing?
   c. If DHCF has not made this data available, does DHCF plan to?

Response:

DHCF has suspended all Medicaid renewals for the duration of the federal public health emergency, which began in FY2020. As such, no responsive data can be produced on this issue.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q38. If DHCF can't auto enroll via data match and the Department must send a notice, what additional follow up will it be doing to prevent procedural terminations?

Response:

DHCF will send notices both 60 days and 30 days prior to termination and will coordinate with managed care organizations (MCOs) to conduct outreach for timely renewals. DHCF will also use our communication vendor to send targeted messages to all Medicaid beneficiaries that are due to renew after the federal public health emergency (PHE) ends, which will help best prevent procedural terminations.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q39. What support can beneficiaries expect to receive at service centers, through the DHS call center, and through the Office of Health Care Ombudsman if they have issues uploading verifications or submitting information through District Direct?

Response:

If beneficiaries are encountering difficulties uploading verifications or submitting information through the District Direct portal/mobile app, they can take one of two actions: (1) visit any of our service centers for in-person support, or (2) contact the District Direct call center for assistance with submitting verification documents through the portal/mobile app. Customer service representatives are provided jobs aids to walk residents through the process of uploading.

If issues persist, DHCF District Access System (DCAS) will assess the issue and contact the representative so they can follow up with the beneficiary regarding the resolution. Call center representatives are trained and instructed to provide three call backs to customer within a 72-hour period.

Should a beneficiary come to the Office of Health Care Ombudsman, located at The Marion S. Barry Jr. Building at 441 4th Street, NW, Washington, DC 20001, an Associate Health Care Ombudsman will come down to the lobby and escort them to the office. They can expect the Ombudsman's Office to provide full-service. The office is open five days a week from 8:15 – 4:45 PM (except holidays), no appointments are necessary. They can also be reached by telephone on (202) 724-7491. An Associate Health Care Ombudsman will assess and determine what is required to assist the beneficiary.

If it is determined that an application or recertification form is needed, an Associate Health Care Ombudsman will complete the application/recertification form on their behalf and have the beneficiary to sign and then will forward the application/recertification form to the appropriate Economic Security Administration (ESA) contacts.

If the request is received telephonically, the Associate Health Care Ombudsman will complete the application/recertification on their behalf and send to The Department on Aging and Community Living (DACL) to have the signature completed telephonically. Once completed, the application/recertification form will be forwarded to the appropriate ESA contacts.

If the beneficiary is there to submit verification documents, an Associate Health Care Ombudsman will make copies of the documents and submit to appropriate contacts at ESA for processing.

If the request is made telephonically, documents can be submitted to 441 4th Street, NW, Washington, DC 20001, or sent to the e-mail of the Ombudsman staff person they contacted, or to healthcareombudsman@dc.gov, which is monitored and responded to daily. Once received, the documents will be forwarded to the appropriate contacts at ESA.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q41. Regarding Health Care Alliance Program re-certifications:

a. For enrollees required to recertify by October 31, 2021, please indicate:

i. The number of enrollees who were required to recertify by October 31, 2021

ii. The number of enrollees in i. who:

i. Successfully completed recertification

ii. Did not successfully complete recertification

iii. Were terminated for failure to recertify by October 31, 2021

iv. Were successfully reinstated following termination for failure to recertify by October 31.

Response:

i. There were approximately 8,500 Alliance and Immigrant Children's Program (ICP) enrollees required to recertify by October 31, 2021.

ii.

i. Approximately 2,400 Alliance/ICP beneficiaries recertified by November 12, 2021, the date when, due to operational issues, the Deputy Mayor for Health and Human Services directed a reinstatement and extension of coverage for all who were due to recertify by October 31.

ii. As of November 12, approximately 6,100 Alliance/ICP beneficiaries were not recertified.

iii. As of November 12, approximately 6,100 Alliance/ICP beneficiaries were terminated for failure to recertify by October 31, 2021.

iv. On November 12, approximately 6,100 Alliance/ICP beneficiaries were successfully reinstated following termination for failure to recertify by October 31, 2021.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q42. In November 2021, the Department of Healthcare Finance modified the recertification deadlines for Alliance participants due to recertify by November 30, 2021 and reinstated participants terminated due to failure to recertify by October 31, 2021. Per DHS's website, the Administration has since modified Alliance recertification deadlines so that individuals required to recertify by September 30, 2021, October 31, 2021, November 30, 2021, and December 31, 2021, will have their recertification deadlines postponed by 6 months.

a. **With respect to participants previously required to recertify by October 31, 2021:**

   i. **Please indicate the number of participants who submitted materials related to recertification prior to October 31, 2021, but whose materials were not processed prior to October 31, 2021.**

   Response: DHS is unable to provide data on how many participants submitted recertification materials prior to October 31, 2021 but were not processed by that date. The information to determine this comes from multiple systems and there is no feasible way to match the data from both places to determine the answer to this question.

   ii. **Please indicate the methods by which the DHCF/DHS determined the number reported in i. above.**

   Response: DHS was able to reach this number by data matching CaseID, first name, last name, DOB, gender, SSN (if available) across three application tracking channels (1) cases submitted through the online portal as an Alliance renewal, (2) registered in ACEDS and pended and (3) the document was located in the DHS task/workflow management tool "Current"

b. **Regarding document submission backlogs more generally:**

   i. **Please explain the reasons for any backlogs of submitted materials related to Alliance recertifications that occurred between September 1, 2021 and the present.**

   Response: The average processing time across all Medicaid programs was thirty (30) days. Medicaid regulations require applications without a disability determination be processed within 45 days. There were some impacts to case processing due to restarting/stopping renewals, deploying a new system, worker learning curve, and case processing capacity

   ii. **Please explain what steps DHCF and DHS are taking to clear any currently existing backlogs and ensure that such backlogs do not occur in the future.**

Response: DHS will continue to monitor all applications/recerts to ensure they are processed timely by providing daily reports to program managers to identify applications that require immediate attention.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q43. Regarding the decision to postpone September-December 31, 2021, recertification deadlines by six months, please explain:

i. **The reasons for this decision**
ii. **How the Department determined that this would allow sufficient time for DHCF/DHS to address current barriers to recertification, including document processing backlogs and any other concerns raised in i., above.**
iii. **Steps that the Department is taking to ensure that barriers to the submission and timely processing of recertifications will be addressed in time for the March-June 30, 2022, recertification periods.**

Responses:

i. DHCF received notification that DHS had a case backlog which impacted the operational processing and tracking of Alliance recertifications. To ensure the agency did not inadvertently terminate Alliance beneficiaries who returned their forms timely, DHCF extended recertifications for an additional 6 months to maintain coverage for these individuals and allow time for ESA to develop a mitigation plan to address the issue.
ii. The Department determined that postponing recertifications would provide DHS time to work on backlogged cases. An internal data analysis indicated a low response rate of Alliance recertifications. Additionally, the launch of District Direct allowed Alliance beneficiaries to complete recertifications and upload verification documents online.
iii. DHS will continue to monitor all applications/recerts to ensure they are processed timely by providing daily reports to program managers to identify applications that require immediate attention. Additional remedies include:

    1) A DCAS MicroStrategy report designed to monitor the scope and the status of pending recertification and renewal applications and is acted on by DPO on a weekly basis.

    2) Streamlined online and mobile renewals for Alliance; which automatically update the case in DCAS, and will send notices automatically.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q44. Please describe any changes to the administration of the Alliance program during FY21, FY22 to date.

Response:

In FY21, the District's public health emergency (PHE), which was initially declared on March 11, 2020, expired on July 25, 2021, following Mayor's Order 2021-096. As a result of this change, renewals and eligibility determinations for the Alliance program resumed. Due to a DHS/ESA processing backlog, DHCF has extended recertification dates for the Alliance and Immigrant Children Program through April 2022.

In addition, the launch of District Direct expanded submission modalities, allowing Alliance beneficiaries and applicants to apply for medical assistance and submit verification documents online. Another change followed the implementation of the Fiscal Year 2022 Budget Support Act, which removed the face-to-face interview requirement to establish eligibility for Alliance applicants beginning in FY22.

DEPARTMENT OF HEALTH CARE FINANCE

Q45. Please describe any changes to the administration of the Alliance program that the Department anticipates implementing during the remainder of FY22?

The Department anticipates implementing the following amendments to the DC Health Care Alliance Program Regulations at 29 DCMR 33:

1. Extend the waiver of the in-person interview requirement through FY22;

2. Establish eligibility criteria consistent with Medicaid Modified Adjusted Gross Income (MAGI) standards, including increasing financial eligibility standards from 200 percent of the Federal Poverty Level (FPL) to 210 percent of the FPL, plus a 5 percent income disregard;

3. Implement new modalities to apply for and renew Alliance program coverage (including telephonic and online means);

4. Provide health coverage to unjustly convicted and imprisoned individuals pursuant to new law entitling unjustly convicted individuals to benefits (D.C. Code § 2–423.02(a)(3)(A));

5. Establish the authority to suspend capitation payment to Managed Care Organizations for an Alliance beneficiary who becomes incarcerated; and

6. Allow DHCF to conduct periodic electronic data matches on District residency between renewal periods and terminate a beneficiary for any unresolved discrepancy.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q46. Please provide an update as to any cost studies that the Administration is doing regarding potential changes to the Alliance's recertification requirements, including but not limited to changing the recertification period for the Alliance from six months to one year. Please provide a copy of such a cost study if it is available.

Response:

A cost study is not currently available. Alliance recertifications have been extended through April 2022. DHCF will monitor both enrollment and cost trends as the recertification process unfolds and use this data to inform any discussion of potential changes to recertification requirements.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PEFORMANCE OVERSIGHT QUESTIONS

Q47. 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 FY21 and FY22, to date, regarding:

Response:

Among those individuals assessed during the PHE, 34 EPD Waiver enrollees have been determined to no longer meet the nursing facility level of care criteria, but have remained enrolled in the EPD Waiver due to Federal public health emergency policy.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PEFORMANCE OVERSIGHT QUESTIONS

Q48. Please report the number of beneficiaries whose reduction in PCA services was tolled due to D.C. or Federal public health emergency protections.

Response:

Among those individuals assessed during the public health emergency, 1,032 individuals were assessed to need fewer hours of PCA services than currently in place, but such reductions were not implemented due to Federal public health emergency policy.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q49: In October 2020, the District began its 5-year plan to transition all Medicaid beneficiaries to an MCO. What role and responsibilities does an MCO have for beneficiaries who are seeking PCA services and/or enrollment in the EPD waiver program?

Response:

As a result of the October 2020 transition of Medicaid fee-for-service (FFS) beneficiaries into managed care, the impacted beneficiaries were able to continue to receive personal care aide (PCA) services. The service category is a covered benefit within the managed care program. Effective October 1, 2020, MCOs were required to honor existing prior authorizations for PCA services through the beneficiaries' existing service provider through the conclusion date of the prior authorization. During this period, MCOs were responsible for contracting with all willing FFS providers that were already known to the beneficiary, to prevent any gaps in care and to retain the provider and beneficiary relationship. Also, during this time, MCOs completed assessments for implementation of new prior authorizations upon conclusion of those in place at the time of transition. All activities were aligned with the requirements to continue services through the federal public health emergency.

Any managed care beneficiary, including those transitioned to managed care in October 2020, interested in receiving services through the EPD waiver program may apply for enrollment into the program. Designated managed care staff refer beneficiaries seeking enrollment into the EPD Waiver for an enrollment evaluation, conducted by the Department of Human Services. If approved for the program, the beneficiary will be disenrolled from the managed care program and subsequently enrolled into the FFS program to receive waiver services, in addition to other Medicaid covered services.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

50. Please report the number of beneficiaries who have experienced the termination of their EPD waiver eligibility since DHCF's implementation of the new contractor to process home healthcare applications and renewals, new computer system to manage the provision of home healthcare benefits, and new assessment tool (InterRAI).

Response:

This appears to be a previously posed question that is no longer relevant and was advanced in 2018 when DHCF's new assessment tool was implemented. Furthermore, it is unclear which "computer system[s]" [sic] or "contractor to process home healthcare applications and renewals" the question refers to.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q51. Please report the number of people who have been approved for 6 hours or fewer (through either the EPD Waiver or State Plan Services), but for whom no hours are actually being billed for reimbursement to DHCF.

a) Can you provide an estimate of the number of home health agencies who will provide only two hours of PCA services per day? If so, how was that estimate obtained?

b) Can you provide an estimate of the number of home health agencies who will provide two to four hours of PCA services per day? If so, how was that estimate obtained?

Response:

A response to this question is not feasible. DHCF cannot conduct this analysis without engaging in a complex data analysis that could not be performed within a reasonable timeframe or without deploying significant resources. There are, further, other reasons hours may not be billed for a given date of service that might confound the results. DHCF does not maintain records of agencies staffing two- or four-hour shifts, as this is dependent on individual staff capacity and can be dynamic.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 OVERSIGHT QUESTIONS

Q52. Please report the number of beneficiaries who have had their home healthcare hours reduced since DHCF's implementation of the new contractor to process home healthcare applications and renewals, new computer system to manage the provision of home healthcare benefits, and new assessment tool (InterRAI).

a) Please also specify the number of beneficiaries who had their home healthcare hours reduced to the point where they were no longer eligible for the EPD waiver.

Response:

This appears to be a previously posed question that is no longer relevant and was advanced in 2018 when DHCF's new assessment tool was implemented. Furthermore, it is unclear which "computer system[s]" [sic] or "contractor to process home healthcare applications and renewals" the question refers to.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q53. Please provide us with the total number of EPD waiver participants.

Response:

The enrollment in the elderly and persons with disabilities (EPD) Waiver is 5,066 as of January 31, 2022.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q54. Please provide us with the total number of EPD waiver participants who are currently receiving more than 16 hours of PCA services per day, 7 days per week as well as:

a) The number receiving 24 hours of PCA services per day, 7 days per week?
b) The number receiving 16-17 hours of PCA services per day, 7 days per week?
c) The number receiving 18-19 hours of PCA services per day, 7 days per week?
d) The number receiving 20-23 hours of PCA services per day, 7 days per week?

Responses:

Based on assessment data from 9,319 assessments completed during FY2021:

a. 2.8 percent of all assessment results recommended 24 hours of personal care aide (PCA) services per day, seven days per week.
b. Another 4.4 percent of assessment results recommended 17 or 18 hours of services per day, with a negligible percentage (four assessments out of the total) recommending 19 to 23 hours per day. Another 4.3 percent of assessments resulted in a recommendation of 16 hours per day.
c. Please see the responses above.
d. Please see the responses above.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q55. Can DHCF describe what review process has been put into place to review large reductions in care and/or terminations from EPD waiver level-of-care that are resulting from the new assessment tool? Regarding the review process, please explain:

a) **Who is involved in the review process? How does the review process work and how long will it take?**
b) **What is the threshold reduction necessary to trigger application of the review process?**
c) **What documents, beyond the InterRAI, are reviewed as part of the review process?**

Responses:

During the PHE, DHCF has not reduced or terminated personal care aide (PCA) or elderly and persons with disabilities (EPD) waiver services due to reassessment.

DHCF's assessment contractor reviews assessments that would reflect a reduction or loss of nursing facility level of care determination. They review 100% of cases with a loss of level of care or reductions in recommended PCA hours greater than three hours. The review process includes the contractor's Medical Director and a supervisory nurse. The review process can vary but typically is complete within 48 hours of assessment completion. Assessments are reviewed for internal correlation and clarification requests are sent back to the assessor for any questions noted in the assessment coding. The assessor would review the correlation questions, make any applicable changes, and submit the assessment. Medical reviewers review any available and relevant medical records at the time of assessment review. This would include such documents as medical histories, discharge summaries, clinical notes, progress notes, and medication lists.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q56. Is DHCF aware of any specific problems regarding Consumer Direct not having the most up-to-date coding of a person's Medicaid status?

Response:

Consumer Direct-DC has access to the District's clinical case management system, which is updated daily through a feed from the District's Medicaid management information system. The Medicaid management information system contains the most recently updated Medicaid eligibility status. There are no known issues with Consumer Direct's access to this information.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q57. Since DCHF began using the interRAI assessment, what percentage of beneficiaries who were receiving 24 hours/day prior to the assessment have been scored by the interRAI to receive 24 hours/day?

Response:

DHCF began using the InterRAI assessment tool in 2018. Individuals receiving 24 hours of personal care aide (PCA) per day prior to the implementation of the interRAI had the right to appeal any assessment recommending a reduction of PCA hours. Moreover, during the federal public health emergency declared in 2020 and still in place as of the production of these responses, any outstanding appeals of reductions in place at the time of the onset of the PHE were further stayed by DHCF's suspension of adverse actions during a PHE.

In June 2018, prior to implementation of DC Care Connect and the use of the interRAI, there were 52 individuals who, throughout that month, averaged 20 or more hours per day according to adjudicated claims for PCA services. In the intervening years, all but one of these individuals have been assessed using the interRAI and have been assessed an average of three times (and as many as five times). Subsequent assessments, generally conducted annually, offer an opportunity to capture changed and improved health status over time. Of the 51 with interRAI assessments, 38 (75 percent) had at least one assessment that recommended 24 hours per day. The average recommended hours of all subsequent assessments for these 51 beneficiaries were more than 20 hours per day.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q58. What, if any, guidance has been provided to Liberty assessors related to (i) completing the assessment and (ii) implementing the 24-hour override? Is this guidance recorded, and if so, where? Please provide a copy of any written protocols, policies, or procedures.

Responses:

All assessment contractor nurse assessors are trained upon hiring and throughout their employment on the use of the interRAI tool using guides and instructional tools available from interRAI. Since late 2018, the District's clinical case management system includes a workflow and mechanism that permits raising the maximum service-hour authorization to 24 hours for individuals assessed who reach the otherwise-standard maximum of 18 personal care aide (PCA) hours upon assessment.

After the nurse assessor completes the level of care assessment, a quality review process in the clinical case management system triggers the approval and quality review workflows by supervisory quality reviewers employed by the assessment contractor and the Medical Director. DHCF provided the contractor with comprehensive training and instructional materials (videos and PowerPoint slides) in December 2018, including to nurse assessors and quality reviewers.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q59. What, if any, guidance has been provided to Comagine related to approving a D.C. resident for 24 hours of PCA services during the reconsideration process? Is this guidance recorded, and if so, where? Please provide a copy of any written protocols, policies, or procedures.

Response:

A reconsideration request alone does not constitute a stay on existing services; however, most reconsideration requests accompany filings of District appeals (fair hearings). If a beneficiary or their representative has filed a timely appeal, the fair hearing is documented within the District's clinical case management system by the case manager or by DHCF, and Comagine, DHCF's utilization review vendor, authorizes services consistent with a documented, outstanding appeal.

When a beneficiary is dissatisfied with a change in the number of hours of PCA services they are receiving, they can request reconsideration of the determination. The assessment and any other materials are presented to Comagine, who will conduct a clinical review and issue a decision. DHCF does not conduct the clinical review, but they do provide the final sign-off of Comagine's decision.

Based on Comagine's decision, a beneficiary may choose to file an appeal and move onto a hearing with an administrative law judge (ALJ). Comagine is responsible for authorizing a beneficiary's current level of PCA services to remain the same while under appeal. DHCF helps at the appeal level by documenting the hearing in the District's clinical case management system. Comagine will use the hearing to then authorize services for beneficiaries if the appeal is filed in a timely manner and contains well-documented evidence to accompany a beneficiary's request.

If an appeal is filed first without reconsideration, then the case will likely be returned to DHCF to perform reconsideration. In some cases, a reassessment is conducted as part of the reconsideration or appeal process, but only if there was an error in either how the original assessment was conducted or processed.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q60. How is the need for safety monitoring with ADLs captured by the interRAI assessment, e.g., if a person is sometimes able to bathe themselves but needs an aide present to ensure they are safe? Has any guidance been provided to Liberty or Comagine regarding including the need for safety monitoring in the assessment of a particular ADL? Please provide a copy of any written protocols, policies, or procedures.

Response:

The interRAI activities of daily living (ADL) scoring has a three-day lookback window of ADL performance. The scoring is a sliding scale of abilities (as outlined by the interRAI usage instructions for coding the actual level of involvement in self-care), detailed as follows:

- Independent;
- Set-up help only;
- Supervision: oversight, encouragement, or cueing provided 3 or more times during the period;
- Limited assistance: person highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance;
- Extensive assistance: person performed part of activity on own, greater than 50%; weight-bearing assistance;
- Maximal assistance: person involved and completed less than 50% of subtasks on own, weight bearing assistance;
- Total dependence: full performance of activity by another; and
- Activity did not occur: ADL activity was not performed by person or others (regardless of ability).

Once the assessment is completed, Clinical Assessment Protocols and Scales results that outline areas of beneficiary need are produced for the Case Manager or supervisory Registered Nurse to review. Nurse assessors may also identify safety concerns during an assessment that are then reported to DHCF to review and resolution.

Outside of ADL assessment, the interRAI has questions about environmental safety (disrepair of home, squalid conditions, inadequate heating and cooling); lack of personal safety (fear), limited access to areas of the home, etc. Medicaid providers can use information gleaned from these items to develop a person-centered service plan, aligned with the plan of care for personal care aide services, to outline interventions related to these areas.

The District added safety monitoring to the PCA responsibilities to ensure beneficiary supervision even while reminding a beneficiary to independently perform activities of daily living. The District has also conducted several Learning Collaborative sessions for HCBS providers about planning and incorporating informal supports and other resources in the person-centered service plan and plan of care.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q61. Given that D.C. and Federal public health emergency protections have tolled the implementation of the amended EPD waiver, including a 16-hour cap on PCA service hours for EPD waiver beneficiaries, when does the District plan on rolling back these protections?

Response:

The District plans to sunset all public health emergency (PHE) policy flexibilities consistent with directives issued by the Center for Medicaid and Medicare services.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q62. What steps has the District taken to ensure that the medical needs of EPD waiver beneficiaries who will be affected by the 16-hour cap on PCA services will be adequately met by other EPD waiver services?

a. **How many people currently receive 17-24 hours of PCA services per day?**
b. **How many Adult Day Health Programs (ADHP) are currently operating in the District?**
c. **What is the current capacity of ADHP programs in terms of number of patients they are able to serve?**
d. **What is the existing unused capacity (i.e., number of unused patient slots) that is available through the District's ADHP programs?**
e. **What communication has the District had with these ADHPs about the impending cap on PCA services and the role the District expects ADHPs to play in meeting complex medical needs of individuals affected by the cap?**
f. **What communication/coordination has the District had with home health agencies regarding any staffing shortages or concerns related to helping beneficiaries transition to and from ADHPs?**
g. **Is there a medical exception for the PCA cap for individuals for whom 24 hours of PCA services is medically necessary because other PCA services are not able to adequately meet their medical needs?**

Responses:

Due to the federal public health emergency (PHE), the District has yet to implement any changes to the total hours of personal care aide (PCA) services available to elderly and persons with disabilities (EPD) Waiver enrollees. Over the course of the last two years, DHCF has used public stakeholder meetings, provider meetings, and community-led coalition meetings to inform the entire stakeholder and provider community about the full complement of services available in the Medicaid program and the waiver itself. These have included periodic "service fairs" in which state plan and non-Medicaid benefits have also been presented in order to ensure that case managers are aware of all services available to Medicaid beneficiaries and no beneficiary relies solely on a single service for their health and well-being.

During the last two years, the District's ADHP capacity has also increased; two new providers entered the program during the PHE (for a new total of 11 enrolled providers). While state plan ADHPs served a monthly average of approximately 150 Medicaid beneficiaries in combination in 2019, the monthly user count now often exceeds 200 beneficiaries. Given the pressures on the health care workforce that have been exacerbated by the public health emergency, ADHPs offer a way to serve more Medicaid beneficiaries in the community when personal care aide staffing is impacted by workforce availability.

Finally, the District's capacity to serve individuals in Medicaid-covered assisted living residences (ALRs) has also increased during the past year, with two new facilities enrolling as EPD Waiver providers during FY2021. Both ADHPs and ALRs increase the opportunity for

community integration for Medicaid beneficiaries in need of long-term services and supports. ADHPs do not report data on their total patient capacity to DHCF.

DEPARTMENT OF HEALTH CARE FINANCE
FY21-22 PERFORMANCE OVERSIGHT QUESTIONS

Q63. What is the District's plan for keeping PCA service and EPD waiver beneficiaries informed about the rolling back of PHE protections?

Response:

The District continues to inform and update its community-based providers about the current timelines for federal public health emergency (PHE) policy and programmatic flexibilities in place through public meetings, which in turn inform and support beneficiaries' understanding and use of their services. Without a defined timeline for the conclusion of the public health emergency, the DHCF long-term care administration (LTCA) has not issued any communications directly to personal care aide (PCA)- and elderly and persons with disabilities (EPD)-using beneficiaries about changes to those flexibilities. LTCA has further developed a plan to sunset service- and eligibility-specific flexibilities on a rolling basis to the extent federal requirements permit, so that beneficiaries experience any PHE-related changes only at the time of their next assessment or redetermination. LTCA has considered the inclusion of PHE-specific informational materials in notices issued after the conclusion of the public health emergency to ensure beneficiaries understand if their services change because of the sunsetting of PHE flexibilities.