DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

1. Please provide the Committee with the following for FY 2022 and to date in FY 2023:

a. The number of full-time equivalents (FTEs) at each organizational level;
b. A list of all FY 2023 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 FY 2022 or to date in FY 2023.

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. Attachment 2 includes the current FTE's and their managers. We have organized them by both SOAR Program and Activity and DIFS Program and Cost Centers to provide. This will provide a true comparison of how you have traditionally reviewed the data and how the information will begin to look in the new accounting system structure. Please also note that every position in DHCF is cost allocated inclusive of both federal and local funding.
c. Please see the response above.
d. For FY 2022 to date in FY 2023, the Office of Rates, Reimbursements and Financial Analysis will establish a new Division due to shifts in how DHCF provides healthcare to District residents. The Financial Analysis division was separated into two distinct divisions to allow staff in each division to provide deeper analysis either in the administrative budget (Financial Business Operations) including budget formulation, justification and execution for administrative functions or the provider analysis (Provider Finance & Analysis) to allow more detailed analysis focused on healthcare cost drivers for services, focusing on utilization and spending trends. The separations promote more efficiency and better data outcomes that provides assistance in decision making.

The organizational changes will be fully implemented no later than the third quarter of FY 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

2. Please provide the Committee with the following for FY 2022 and to date in FY 2023:

a. Please describe the agency's procedures for investigating allegations of sexual harassment or misconduct committed by or against its employees.
b. List and describe any allegations received by the agency in FY 2022 and FY 2023, to date, and whether or not those allegations were resolved.

Response:

a. DHCF follows the Mayor's Order 2017-313. DHCF promptly conducts thorough investigations for all sexual harassment allegations. DHCF interviews all implicated parties and works closely with DHCF's Office of the General Counsel to report findings to the Mayor's office as directed.
b. DHCF did not have any sexual harassment claims for FY 2022 and FY 2023 to date.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

3. Please provide the Committee with the following for FY 2022 and to date in FY 2023:

a. How many performance evaluations did the agency complete in FY 2022?
b. How many performance improvements plans were issued in FY 2022?
c. How many employees have submitted SMART goals or other relevant workplans in FY 2023? For each question, provide the total number and the percentage of total employees.

Response:

a. In FY 2022, there were a total of 207 completed performance plans. DHCF completed 182 performance evaluations which equals 88%.
b. DHCF did not have any performance improvement plans issued in FY 2022.
c. As practice, employee SMART goals (Individual Performance Plans) and the Individual Development Plans (IDPs) are entered and submitted by the immediate supervisor. For FY 2023, there are 220 eligible employees; DHCF completed 213 Individual Performance Plans (IPPs) which parallels to 97%.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

4. Please provide the following budget information, in Microsoft Excel, for the agency, including the amount budgeted and actually spent for FY 2022 and FY 2023, to date. In addition, please describe any variance between the amount budgeted and actually spent.

a. At the agency level, please provide information broken out by source of funds and by Comptroller Source Group and Comptroller Object;

b. At the program level, please provide the information broken out by source of funds and by Comptroller Source Group and Comptroller Object; and

c. At the activity level, please provide the information broken out by source of funds and by Comptroller Source Group.

Response:
Please see the attachment.

Tab 1: A. FY22 Budget vs Expenditure Total Agency by Fund with explanations (SOAR Structure) and CSG

Tab 2: A. FY23 Budget vs Expenditure Total Agency by Fund (DIFS structure change and thru December 31, 2022) and CSG

Tab 3: B-C FY22 Budget vs Expenditure by Program and Activity and CSG

Tab 4: B-C FY23 Budget vs Expenditure by Program and Activity and CSG

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

5. **Please provide a complete accounting of all intra-district transfers received by or transferred from the agency during FY 2022 and all interagency budget processes for FY 2023, to date, where the agency is a buyer and seller. For each, please provide a narrative description as to the purpose of the intra-district transfer and interagency budget process, and which programs, activities, and services within the agency the intra-district transfer and interagency budget process affected.**

Response:
Please see "Attachment 1 to Q5" for DHCFs Intra District Report.

Please note that the FY 2023 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 FY 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

6. **Please provide a complete accounting of all reprogrammings received by or transferred from the agency in FY 2022 and FY 2023, to date. For each, please provide a narrative description as to the purpose of the transfer and which programs, activities, and services within the agency the reprogramming affected.**

Response:
Please see "Attachment 1 to Q6" for reprogrammings received by and transferred from DHCF during FY22 and to date in FY23, including a description of the purpose of the transfer and which DHCF programs, activities, and services were affected.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

7. **Please provide the following information for grants/sub-grants awarded to and by the agency in FY 2022 and FY 2023, to date, broken down by program and activity:**
    - **a. Grant Number/Title;**
    - **b. Approved Budget Authority;**
    - **c. Funding source;**
    - **d. Expenditures (including encumbrances and pre-encumbrances);**
    - **e. Purpose of the grant;**
    - **f. Organization or agency that provided or received the grant;**
    - **g. Grant amount;**
    - **h. Grant deliverables;**
    - **i. Grant outcomes, including grantee/subgrantee performance;**
    - **j. Any corrective actions taken or technical assistance provided;**
    - **k. Agency program and activity supported by the grant; and**
    - **l. Agency employee responsible for grant deliverables.**

Response:
Please see "Attachment to Q7" for the information requested for all grants awarded to DHCF during FY22 and to date in FY23. The current fiscal year expenditures are through the first quarter, December 31, 2022.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

8. Please provide the following information for all contracts, including modifications, active during FY 2022 and FY 2023, to date, broken down by program and activity:

- **a. Contract number;**
- **b. Approved Budget Authority;**
- **c. Funding source;**
- **d. Expenditures (including encumbrances and pre-encumbrances);**
- **e. Purpose of the contract;**
- **f. Name of the vendor;**
- **g. Original contract value;**
- **h. Modified contract value (if applicable);**
- **i. Whether it was competitively bid or sole sourced;**
- **j. Final deliverables for completed contracts;**
- **k. Any corrective actions taken or technical assistance provided; and**
- **l. Agency employee(s) serving as Contract Administrator.**

Response:
Please see Attachment to Q8 for the information requested for all contracts during FY22 and to date in FY23.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

9. Please provide a list of all Department of General Services work orders submitted in FY 2022 and FY 2023, to date, for facilities operated by the agency. Please include the date the work order was submitted, whether the work order is completed or still open, and the date of completion (if completed).

Response:
In FY 2023 (January), there were 24 service tickets submitted, and 24 were closed. For FY 2022 (April – December 2022), there were 96 service tickets submitted, and all 96 were closed.

ORDER NO BUILDING MAIN STATUS DATE REQUEST DATE COMPLETED

FY2023 – Total Opened = 24 and Total Closed=24

732537	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	25-Jan-23	25-Jan-23
732532	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	25-Jan-23	25-Jan-23
732531	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	25-Jan-23	25-Jan-23
732273	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	23-Jan-23	23-Jan-23
732271	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	23-Jan-23	23-Jan-23
732006	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	19-Jan-23	19-Jan-23
731732	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	17-Jan-23	17-Jan-23
731724	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	17-Jan-23	23-Jan-23
731123	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	10-Jan-23	10-Jan-23

FY2022 – Total Opened = 96 and Total Closed= 96

730154	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	28-Dec-22	28-Dec-22
730020	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	27-Dec-22	27-Dec-22
729706	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	21-Dec-22	21-Dec-22
729136	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Dec-22	15-Dec-22
728445	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	7-Dec-22	7-Dec-22
726756	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	17-Nov-22	17-Nov-22
726549	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Nov-22	15-Nov-22
726533	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Nov-22	15-Nov-22
726484	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Nov-22	15-Nov-22
726390	OJS BUILDING (Marion S. Barry, Jr. Building)	On Hold for Parts	14-Nov-22	1/8-on hold
726337	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	14-Nov-22	14-Nov-22
725861	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	7-Nov-22	7-Nov-22
725646	OJS BUILDING (Marion S. Barry, Jr. Building)	On Hold for Parts	3-Nov-22	1/8 -on hold
725383	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1-Nov-22	1-Nov-22
725328	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1-Nov-22	1-Nov-22
724883	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	26-Oct-22	26-Oct-22
724466	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	20-Oct-22	20-Oct-22
723875	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	14-Oct-22	14-Oct-22
723837	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	14-Oct-22	14-Oct-22
723704	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	13-Oct-22	13-Oct-22
723703	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	13-Oct-22	13-Oct-22
723321	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	6-Oct-22	6-Oct-22
723259	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	6-Oct-22	6-Oct-22

720368	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	7-Sep-22	7-Sep-22
719736	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	31-Aug-22	31-Aug-22
719701	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	31-Aug-22	31-Aug-22
719282	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	29-Aug-22	29-Aug-22
719260	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	29-Aug-22	29-Aug-22
718836	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	25-Aug-22	25-Aug-22
718634	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	24-Aug-22	24-Aug-22
718611	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	24-Aug-22	24-Aug-22
718573	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	24-Aug-22	24-Aug-22
718472	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	23-Aug-22	23-Aug-22
718438	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	23-Aug-22	23-Aug-22
718052	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	19-Aug-22	19-Aug-22
718015	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	19-Aug-22	19-Aug-22
717832	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	17-Aug-22	17-Aug-22
717567	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	16-Aug-22	16-Aug-22
717539	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Aug-22	15-Aug-22
717513	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Aug-22	15-Aug-22
717489	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Aug-22	15-Aug-22
717434	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Aug-22	15-Aug-22
717397	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Aug-22	15-Aug-22
717150	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	11-Aug-22	11-Aug-22
716857	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	9-Aug-22	9-Aug-22
716694	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	8-Aug-22	8-Aug-22
716367	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	5-Aug-22	5-Aug-22
716030	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3-Aug-22	3-Aug-22
715412	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	28-Jul-22	28-Jul-22
715173	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	26-Jul-22	26-Jul-22
714961	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	25-Jul-22	25-Jul-22
714608	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	20-Jul-22	20-Jul-22
714535	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	20-Jul-22	20-Jul-22
713905	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	13-Jul-22	13-Jul-22

713904	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	13-Jul-22	13-Jul-22
713902	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	13-Jul-22	13-Jul-22
713892	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	13-Jul-22	13-Jul-22
713881	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	13-Jul-22	13-Jul-22
713535	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	11-Jul-22	11-Jul-22
713179	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	7-Jul-22	7-Jul-22
713074	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	6-Jul-22	6-Jul-22
713068	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	6-Jul-22	6-Jul-22
712672	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	30-Jun-22	30-Jun-22
712666	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	30-Jun-22	30-Jun-22
712633	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	29-Jun-22	29-Jun-22
712412	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	27-Jun-22	27-Jun-22
712050	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	23-Jun-22	23-Jun-22
712009	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	22-Jun-22	22-Jun-22
711917	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	22-Jun-22	22-Jun-22
711744	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	17-Jun-22	17-Jun-22
711410	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Jun-22	15-Jun-22
711407	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Jun-22	15-Jun-22
711406	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	15-Jun-22	15-Jun-22
710991	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	10-Jun-22	10-Jun-22
710877	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	9-Jun-22	9-Jun-22
710738	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	8-Jun-22	8-Jun-22
710292	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3-Jun-22	3-Jun-22
710037	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1-Jun-22	1-Jun-22
709887	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	31-May-22	31-May-22
709816	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	31-May-22	31-May-22
709726	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	27-May-22	27-May-22
709523	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	26-May-22	26-May-22
709402	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	25-May-22	25-May-22
709390	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	25-May-22	25-May-22
709271	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	24-May-22	24-May-22
708991	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	20-May-22	20-May-22

708897	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	20-May-22	20-May-22
708689	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	18-May-22	18-May-22
708587	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	18-May-22	18-May-22
708148	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	13-May-22	13-May-22
708102	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	12-May-22	12-May-22
707924	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	11-May-22	11-May-22
707777	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	10-May-22	10-May-22
707727	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	10-May-22	10-May-22
707530	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	9-May-22	9-May-22
706308	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	26-Apr-22	26-Apr-22

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

10. Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY 2022 and FY 2023, to date. 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 FY 2022 and FY 2023 to date; and**
- **e. FY 2022 and to date FY 2023, to date, expenditure of funds, including purpose of expenditure.**

Response:
Please see "Attachment to Q10" for a complete accounting of DHCF's Dedicated Tax and Special Purpose Revenue Funds for FY 2022 and to date in FY 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

11. For each grant lapse that occurred in FY 2022, 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 FY 2023.**

Response:
Please see the attachment to Q11 for DHCF's grant lapse report.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

12(I). Please provide DHCF's capital budgets for FY22 and FY23, to date, 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 Q12(I)" for DHCF's capital budgets for FY22 and FY23.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

12(II). Please provide DHCF's fixed costs budget for FY22 and FY23, to date, and include the following information:

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

Response:

Please see "Attachment to Q12(II)" for DHCF's fixed cost budget and actual dollars spent for FY22 and to date in FY23, including the source of funding

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

14. Did DHCF meet the objectives set forth in the performance plan for FY 2022? 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:
Yes. In FY 2022, DHCF had 15 performance measures across four areas:

1. Access to healthcare,
2. Delivery of high-quality care,
3. Deterring Medicaid fraud and
4. Processing payment.

Only one metric, "number of referrals to the Medicaid Fraud Control Unit or other agencies for criminal of civil resolution" was unmet. Our target was 14 cases, but we only had 11 referrals. This metric is highly dependent on the number and type of cases the agency receives and believes should be referred for investigation.

For FY 2022, DHCF's top three accomplishments were:

1. Continue to provide and manage Medicaid under the COVID-19 Public Health Emergency
2. Advances in maternal health: Extended postpartum coverage from 60 days to 12 months and expanded related maternal health services including developing doula services for beneficiaries.
3. Cedar Hill Regional Medical Center, GW Health broke ground in February 2022 and announced $17.1 million in private funding to build a larger facility. The hospital is now under construction and expected to open early calendar year 2025.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

15. What are DHCF's performance objectives for FY 2023?

Response:
For FY 2023, DHCF is maintaining its fifteen performance measures and three primary performance objectives to

1. Provide and manage Medicaid under the COVID-19 Public Health Emergency *AND manage the unwinding of the public health emergency and its impacts to beneficiaries*.
2. Advance maternal health access; and
3. Keep the Cedar Hill Regional Medical Center on schedule.

We also have five strategic initiatives for FY 2023. They include:

Produce Rx Program: Continuing our FY 2022 efforts, DHCF will ensure compliance with the guidelines and deadlines within the American Rescue Plan Act for the Produce Rx Program, which allows medical professionals to prescribe fresh fruit and vegetables to patients experiencing diet-related chronic illnesses while providing additional support for patients living in poverty. DHCF will award one (1) grant for one (1) base year and one (1) option year to enhance and expand produce prescription interventions for Medicaid and other public insurance program beneficiaries in the District.

Behavioral Health Integration: Continuing from FY 2022 progress, DHCF will expand the services included in the Medicaid Managed Care contracts to include behavioral health services, currently carved-out of the managed care contracts, as part of a multi-year project to integrate physical and behavioral health. This integration will help improve coordination and increase the provision of whole person care.

New Hospital and Health System: Continue to provide oversight of the implementation of the new hospital and health system east of the river, including the construction of the new Cedar Hill GW Health Regional Medical Center and two urgent care facilities. In September 2020, the council passed the mayor's proposal to establish a comprehensive health care system east of the river in partnership with Universal Health Services. This includes a new full-service hospital and two new urgent cares in wards 7 and 8.

Health IT Enhancements: Continuing from FY 2022 progress on several DC HIE projects with the District's Designated HIE Partner, CRISP, that will substantially enhance provider uses of the DC HIE's use of population health analytics, inform clinical decision-making, and improve health outcomes. In FY 2023, DHCF will implement a suite of new population health analytic tools via CRISP Reporting Services (CRS), and a new approach to patient panel management, which will enable users are able to submit relevant patient data and identify patients care programs to support care coordination. The timeline for this project aligns with the term of the

current MOA with the District's competitively selected DC HIE Designated HIE Partner, CRISP.

Electronic Advance Directives via the Health Information Exchange: Continuing FY 2022 progress in collaborations with sister agencies (DOH, DBH, DDS) and community partners (DCPCA, DCMS, DCHA) will design, develop, and implement of a system to exchange advance care planning forms among providers using the DC Health Information Exchange (HIE). This initiative addresses one of the recommendations from the Mayor's Commission on Health Care Systems Transformation.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

16. Please provide the Committee with the following for FY 2022 and to date in FY 2023:

a. How many grievances were filed against DHCF providers and DHCF during FY 2022?
b. Please briefly describe the grievances filed and DHCF's response. How many of these grievances did DHCF find in favor of the beneficiary?

Response:

a. There were no grievances filed against DHCF pertaining to any employee during FY 2022.

a./b. In FY 2022, the Office of Health Care Ombudsman received 141 grievances filed against DHCF and DHCF providers. Of the 141 grievances filed, 133 (94%) were closed in favor of the beneficiary. The types of grievances filed primarily fall under three categories: Access to Care/Service, Quality of Service, and Non-payment Challenges. The top category for grievances filed was for Quality of Service. Under this category, the top complaint was regarding care provided by nursing homes/rehabilitation facilities (40 or 28%).

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

17. Provide an update on ARPA fund budgets and expenditures for FY 2022 and FY 2023, to date, including:

a. Amounts originally budgeted and for which program, activity, and CSG;
b. Amounts expended by program, activity, and CSG;
c. Amounts obligated, encumbered, or pre-encumbered by program, activity, and CSG;
d. A narrative explanation for reprogramming ARPA funds by program, activity, and CSG;
e. A narrative explanation on the progress of spending or obligating ARPA funds, including any contributing factors that may have delayed expenditures.

Response:

a-c. Please see the attachment to Q17. The attachment includes two tabs that respond to Questions A through C. One tab provides a description of each project currently approved by the federal Centers for Medicare and Medicaid Services (CMS). The second tab provides expenditures by the initiative for FY 2022 and FY 2023 through December 31, 2022 (or FY 2023, Quarter 1).

d. The HCBS ARPA funds is a non-lapsing local revenue funds. Therefore, each year the funds need to be reprogrammed to shift the budget authority from one fiscal year to the next to align with remaining revenue. The original budgets are established based on the attachment for the entire length of the project, FY 2022 through March of FY 2025 based on the CMS approved plan. Each year, based on spending, DHCF will complete a reprogramming to align once the previous year has closed. As a result of the implementation of the new DIFS accounting system, DHCF must submit additional reprogramming's to align with the DIFS structure.

e. DHCF was not able to begin many of the projects in FY 2022 because DHCF did not have budget authority for the HCBS ARPA Non-Lapsing fund until late in the fiscal year. The attachment to Q17 provides an overview of spending by project for FY 2022.

In FY 2023, DHCF in collaboration with DDS and DBH has continued programs started in FY 2022 and began implementation of new projects in FY 2023. Projects include increased rates, technical assistance to HCBS providers to become more sustainable health care agencies, and HCBS rate studies. Two main initiatives assisting to address the workforce shortages in healthcare immediately:

1. In FY 2023 Quarter 1, DHCF was able to issue grant opportunities to pay three types of bonus payments (Vaccine, Retention and Recruitment and Conversation) and to Direct Service Professionals (DSP's) that work in home and community-based settings. DHCF started payments in January and payments will be completed in February for all eligible providers.
2. Enhanced wages for DSP's working for Medicaid Providers in a HCBS setting: a supplemental payment will be provided in FY 2023 and FY 2024 with rate implementation in FY 2025 to pay support the cost of paying DSP's an average of

117.6% of living wage. DHCF will fully implement the increase in FY 2024 before the FY 2025 deadline. DHCF began working with eligible providers in November and has continued to provide assistance in submitting documentation. Payments will be issued no later than the end of February.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

18. 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 FY 2022 and FY 2023, to date.

Response:
Please see "Attachment to Q18" for DHCF's service level breakout of expenditures for Activity Codes 5001 (Medicaid Provider Payments), 5002 (Medicaid Public Provider Payments), and 5003 (Alliance Provider Payments) for FY 2022 and FY 2023, to date.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

19. 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 for FY 2022 and FY 2023, to date.

Response:
For costs associated with the Medicaid program, please see the response to question 18. For utilization data, please see "Attachment to Q19." Enrollment information is updated monthly and available on the DHCF website at https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports.

DHCF is unable to provide statistical information by gender at this time.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

20. Identify each District of Columbia agency that submitted Medicaid claims in FY 2022 and FY 2023, to date, and include the following information:

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

Response:

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

(b) Based on FY22 - 23 denied claims history, the most common reasons for denials were:
- Exact duplicate claim
- Beneficiary name mismatch
- Ineligible program code
- Service covered by MCO
- Beneficiary not eligible/not found

(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 Dept of Behavioral Health (DBH)	Within agency
DC Fire Department & Ambulance Services (FEMS)	Vendor: Digitech

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.

(d) Currently, there are no new opportunities for integration of other District agencies into the ASO, due to the following reasons: (1) procurement of their own billing vendor, (2)

discontinuance of enrollment with DC Medicaid, or (3) no longer providing Medicaid reimbursable services.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

21. Please provide copies of any investigations, reviews, or program/fiscal audits completed on programs and activities within DHCF during FY 2022 and FY 2023, to date, 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.

   During FY2022-FY2023, CMS completed Reporting Year (RY) 2021's PERM Audit process and approved DHCF's corrective action plan to address identified errors. The RY 2021 improper payment rates have been 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]. DHCF's approved CAP is being reviewed by CMS on a quarterly basis. The first quarterly CAP review meeting took place on January 27, 2023 and discussed steps DHCF has taken to address identified PERM errors in the areas of Medical Records, Data Processing, and Eligibility reviews. DHCF is optimistic that it will be able to complete the identified corrective actions by the end of FY2023.

   CMS has also initiated the PERM RY24 process. DHCF is working with a PERM Statistical Contractor, Review Contractor, and Eligibility Review Contractor to conduct PERM activities. DHCF has provided two data productions at this time, and is working with the various contractors to ensure a smooth and efficient PERM Cycle.

2. *CMS MCO Focused Review:* CMS conducted a focused review of DHCF's Division of Program Integrity (PI), with a specific focus Medicaid Managed Care Organizations (MCO) program integrity activities in June 2022. The review was a comprehensive overview of all PI activities, both within DHCF and within each of the District's 3 MCOs that took place over 3 days. CMS will be issuing a draft findings report in the coming months, but provided 10 preliminary observations during a June 2022 exit conference. DPI has taken substantial actions to address the observations, while will strengthen and improve PI oversight activities of the MCOs as the agency transitions to a primarily managed care model.

3. *Unified Program Integrity Contract (UPIC):* DPI has paired with the Northeastern UPIC to conduct audits and recover overpayments. The NEUPIC allows for the coordination and integration of existing CMS oversight functions into a single contractor and allows for PI functions

[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

to span Medicare claims data in addition to Medicaid. The NEUPIC works with a variety of states in the Northeast, and DPI meets bi-monthly with the UPIC to discuss leads and developing areas of PI concern. In addition, the NEUPIC recently selected the District to work on a project developing best practices for oversight of the MCO program that will be used to develop best practices to be shared with other Medicaid programs across the country. This project is still under development but will be an exciting opportunity for the District to be at forefront of innovation in PI activities in the managed care realm.

Q21 - Audit Details
FY 2022

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
1	A01 - Physician, Group Practice	Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation Services)	Lack of documentation to support billing and reimbursement for Physician Services (New Patient Visits, Initial Hospital Care and Consultation Services)	Limited	$0.00	$169.63	$2.40	$167.23
2	A01 - Physician, Group Practice	Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation Services)	Lack of documentation to support billing. Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation services)	Limited	$0.00	$13,796.32	$275.37	$3,435.36
3	A00 - Physician MD	Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation Services)	Lack of documentation to support billing. Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation services)	Limited	$0.00	$5,638.51	$179.38	$4,745.83
4	A00 - Physician MD	Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation Services)	Lack of documentation to support billing. Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation services)	Limited	$0.00	$18,000.00	$101.98	$8,265.49
5	A00 - Physician MD	Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation Services)	Lack of documentation to support billing. Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation services)	Limited	$0.00	$317.73	$13.23	$99.91
6	A00 - Physician MD	Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation Services)	Lack of documentation to support billing. Physician Services Review (New Patient Visits, Initial Hospital Care and Consultation services)	Limited	$0.00	$1,086.89	$219.83	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
7	W02 - EPD Waiver	Case Management	Case Management	Moderate	$1,541.40	$1,541.40	$1,541.40	$0.00
8	K00 - Dentist	Provisional Crown D2799 billed on routine restoration performed within 90 days	PERM- (PERM ID: DCM1704F134). Audit Recoupment Completed.	Limited	$21,600.00	$21,600.00	$3,941.81	$10,898.81
9	K00 - Dentist	Crowns, RCT and Extractions	The dental review revealed a 77% error rate. The review consisted of reviewing 219 claim lines, of which 168 claim lines were not supported due to Insufficient documentation to support service and failure to provide records.	Limited	$55,526.00	$36,000.00	$2,642.52	$0.00
10	L00 - Home Health Agency	Payment Error Rate Management (PERM) Audit Review.	PERM Audit. DHCF is requesting to recoup the monies identified in the amount of $ 27,714.69	High	$0.00	$271.20	$271.20	$0.00
11	D00 - Hospital, General	PERM	PERM - Audit completed. Recoupment balanced $0	Limited	$568.94	$568.94	$568.94	$0.00
12	P02 - Office State Superintendent of Ed	PERM	PERM/error overpayment	Limited	$1,893.54	$1,893.54	$1,893.54	$0.00
13	A01 - Physician, Group Practice	PERM	PERM/overpayment error	Moderate	$48.32	$48.32	$48.32	$0.00
14	X02 - Clinic, Mental Health	PERM	PERM	Moderate	$0.00	$128.70	$128.70	$0.00
15	W02 - EPD Waiver	EPD Waiver Personal Emergency Response Systems	EPD Waiver Personal Emergency Response Systems	Moderate	$9,889.50	$3,135.00	$1,859.25	$1,275.75
16	F00 - Nursing Facility	PERM	In addition to the Recovery of Overpayment, a Plan of Correction and the Documentation Matters Quiz was completed by the provider.	Limited	$0.00	$1,387.00	$1,387.00	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
17	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	DBH FAILED CLAIMS AUDIT- Overpayment of $3,968.32	Moderate	$8,924.91	$3,968.32	$3,968.32	$0.00
18	D03 - Hospital, Psychiatric Private	PERM	Provider paid by check and submitted POC along with the training.	Limited	$0.00	$11,488.05	$2,871.99	$0.00
19	H00 - Pharmacy, Retail	PBM audit	PBM audit	Moderate	$58,237.57	$14,158.82	$5,561.43	$8,597.39
20	T01 - Mental Health Rehab Services	PERM	PERM Audit: PERM IDs are as follows: MR2: DCC1704F113, DCC1704F114, DCC1704F143, DCC1704F145, DCC1704F174, DCC1704F175 MR6: DCC1701F131 MR9: DCC1701F182, DCC1702F099, DCC1702F162, DCC1702F167, DCC1702F190, DCC1703F157, DCC1703F163, DCC1703F166, DCC1703F173, DCC1704F132, DCC1704F140	Moderate	$1,921.65	$1,921.65	$1,921.65	$0.00
21	H00 - Pharmacy, Retail	Pharmacy Claims Review.	Pharmacy Claims Review.	Moderate	$13,916.08	$6,364.74	$6,364.74	$0.00
22	H00 - Pharmacy, Retail	Recoupment	Recoupment	Moderate	$1,092.70	$1,092.70	$1,092.70	$0.00
23	H00 - Pharmacy, Retail	Recoupment	Recoupment	Moderate	$1,903.81	$1,903.81	$1,318.61	$0.00
24	H00 - Pharmacy, Retail	PBM audit	PBM audit	Moderate	$23,593.92	$7,985.34	$3,992.70	$3,992.64
25	H00 - Pharmacy, Retail	Recoupment	Recoupment	Moderate	$29,264.52	$10,313.92	$7,674.78	$0.00
26	W02 - EPD Waiver	EPD Waiver Adult Day Health (S5100, U3, CR)	EPD Waiver Adult Day Health (S5100, U3, CR)	Moderate	$415.02	$415.02	$415.02	$0.00
27	W01 - IDD Waiver	Supported Living T2016 U8 HI CR	Supported Living T2016 U8 HI CR	Moderate	$17,215.36	$16,750.08	$16,750.08	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
28	H00 - Pharmacy, Retail	Pharmacy	Provider mailed check for additional amount $1,084.66 identified during the data validation.	Moderate	$6,497.36	$591.92	$591.92	$0.00
29	W02 - EPD Waiver	ASSISTED LIVING; WAIVER, PER DIEM	ASSISTED LIVING; WAIVER, PER DIEM	Moderate	$192.85	$192.85	$192.85	$0.00
30	H00 - Pharmacy, Retail	Pharmacy	Pharmacy	Moderate	$0.00	$9,779.00	$9,779.00	$0.00
31	H00 - Pharmacy, Retail	Pharmacy	PBM- Overpayment Recovery	Moderate	$1,791.21	$1,113.45	$1,113.45	$0.00
32	Q01 - Hemodialysis , Freestanding	Self-audit from prov. billing incorrectly for J1200 J1644	PBM. Overpayment Recovery. Data validation done for the provider self-audit. Additional claims identified paid for the amount of $1,084.66 not included on provider's self-audit spreadsheet. Provider sent check for Two Thousand Nine Hundred Forty-Six Dollars and Fifty-Nine cents ($ 2,946.59). Final letter for the left amount sent to provider. Additional check received on 1/24/22 for $1,084.66 to complete total recoupment of $4,031.25	Limited	$0.00	$4,031.25	$1,084.66	$0.00
33	W01 - IDD Waiver	Group Companion Services	Group Companion Services	Moderate	$80,161.38	$60,772.27	$60,772.27	$0.00
34	T01 - Mental Health Rehab Services	Annual MHRS 2019	Missing documentation. Invalid treatment, Insufficient documentation. Medically Unnecessary.	Moderate	$1,431.76	$1,431.76	$1,431.76	$0.00
35	T01 - Mental Health Rehab Services	Annual MHRS 2019	PBM- Audit Recovery Completed on 11/7/2022	Moderate	$2,852.61	$2,852.61	$2,852.61	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
36	H00 - Pharmacy, Retail	Audit Focus: Pharmacy Claims Review	RX RTS (Refilled Too Soon) Previously filled on 03/30/2021 for a 60-day supply. RX RTS (Refilled Too Soon) Previously filled on 05/26/2021 for a 60-day supply.	Moderate	$540.43	$540.43	$540.43	$0.00
37	H00 - Pharmacy, Retail	Audit Focus: Pharmacy Claims Review	IP - Invalid Prescription - Audit Report indicates that eRx was used to generate Rx, but no original electronic prescription image with eRx tracer, message id, or authorization info provided IP - No Appeal Documentation Provided. PBM Overpayment Recovery. Audit completed. Recoupment balance due $0.00.	Moderate	$43,249.55	$157.08	$157.08	$0.00
38	H00 - Pharmacy, Retail	PBM- Pharmacy Audit Recovery.	PBM- Pharmacy Audit Recovery.	Moderate	$131,789.55	$23,712.47	$23,712.47	$0.00
39	H00 - Pharmacy, Retail	PBM- Pharmacy Audit Recovery.	PBM: overpayment $0.00 balance.	Moderate	$14,266.66	$14,266.66	$10,700.01	$3,566.65
40	H00 - Pharmacy, Retail	PBM- Pharmacy Audit Recovery.	PBM- Pharmacy Audit Recovery.	Moderate	$23,457.23	$22,676.55	$15,891.98	$6,784.57
41	H00 - Pharmacy, Retail	Recoupment	PBM- Pharmacy Audit Recovery.	Moderate	$4,224.11	$2,783.30	$2,783.30	$0.00
42	H00 - Pharmacy, Retail	Recoupment	PBM- Pharmacy Audit Recovery.	Moderate	$5,634.79	$5,634.79	$5,634.79	$0.00
43	H00 - Pharmacy, Retail	Recoupment	PBM- Pharmacy Audit Recovery.	Moderate	$18,151.68	$16,704.36	$16,704.36	$0.00
44	W02 - EPD Waiver	Billing after Date of Death	Billing after Date of Death	Moderate	$270.51	$270.51	$270.51	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
45	W02 - EPD Waiver	Billing after Date of Death	Billing after Date of Death	Moderate	$270.51	$270.51	$270.51	$0.00
46	W01 - IDD Waiver	In Home Supports (99509) along with Companion Services (S5135)	Approval granted for offsets of $500/ week until total amount of recoupment is paid	Moderate	$2,044.26	$2,044.26	$2,044.26	$0.00
47	T01 - Mental Health Rehab Services	Telemedicine Claims MHRS FY2020	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$0.00	$388.32	$388.32	$0.00
48	T01 - Mental Health Rehab Services	Telemedicine Claims MHRS FY2020	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$0.00	$121.35	$121.35	$0.00
49	T01 - Mental Health Rehab Services	New Provider Claims MHRS FY2021	Medicaid Repayment Demand for 2021 MHRS Focused Investigation Claims Audit	Moderate	$0.00	$2,586.24	$2,586.24	$0.00
50	T01 - Mental Health Rehab Services	Telemedicine Claims MHRS FY2020	Final determination Reason: insufficient documentation	Moderate	$0.00	$24.27	$24.27	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
51	T01 - Mental Health Rehab Services	New Provider MHRS FY 2020	DBH Audit Findings: Medically unnecessary: plan is blank-goals/objectives/interventions not seen; service not covered on treatment plan. Insufficient documentation: did not justify the amount of time claim; no consumer response, no intervention, did not describe the service claimed; content within encounter note unclear. Invalid treatment plan: signed by AQP after date of service. Missing document: no encounter note found to support claim; no treatment plan found for date of service. Encounter note: notes with overlapping service times. False documentation: note documents that service took place in a library and per websites none open before 9am; note signed before start and/or stop time.	Moderate	$0.00	$2,946.99	$2,946.99	$0.00
52	T01 - Mental Health Rehab Services	New Provider MHRS FY19	Final Determination Reasons: Invalid treatment plan. Medically unnecessary. Service improperly billed. Encounter note does not substantiate claim. Missing documentation. Diagnostic Assessment missing evidence of second AQP participation in the assessment Insufficient documentation.	Moderate	$0.00	$4,074.70	$4,074.70	$0.00
53	T01 - Mental Health Rehab Services	Telemedicine MHRS 2020	Final Determination Reasons: Encounter note does not substantiate claim. Insufficient documentation.	Moderate	$0.00	$72.81	$72.81	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
54	T01 - Mental Health Rehab Services	New Provider MHRS 2020	Final Determination Reasons: Medically unnecessary. Encounter note does not substantiate claim. Insufficient documentation. Service improperly billed. Invalid treatment plan. Missing documentation. False documentation.	Moderate	$0.00	$2,815.12	$2,815.12	$0.00
55	T01 - Mental Health Rehab Services	New Provider MHRS 2019	Final Determination Reason: Medically unnecessary. Insufficient documentation. Encounter note does not substantiate claim. Invalid treatment plan. Service improperly billed.	Moderate	$0.00	$2,940.84	$2,940.84	$0.00
56	T01 - Mental Health Rehab Services	New Provider MHRS FY2019	Recoupment. Check#1 dated 4/8/2022, Check#2 dated 4/19/2022, Check #3 dated 4/19/2022; Check #4 dated 4/29/2022; Check #5 dated 5/6/2022; Check #6 dated 5/13/2022; Check#7 dated 5/20/2022; Check #8 dated 5/31/2022	Moderate	$0.00	$2,440.62	$2,440.62	$0.00
57	T01 - Mental Health Rehab Services	Telemedicine MHRS 2020	Final Determination Reasons: Insufficient documentation. Service improperly billed. Medically unnecessary. False documentation. Encounter note does not substantiate claim.	Moderate	$0.00	$533.94	$533.94	$0.00
58	T01 - Mental Health Rehab Services	Telemedicine MHRS 2020	Final Determination Reasons:Insufficient documentation	Moderate	$0.00	$266.97	$266.97	$0.00
59	T01 - Mental Health Rehab Services	Telemedicine MHRS FY2020	Final Determination Reasons: Medically unnecessary. Insufficient documentation.	Moderate	$0.00	$965.90	$965.90	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
60	T01 - Mental Health Rehab Services	Telemedicine MHRS FY2020	Final Determination Reasons: Insufficient documentation. Medically unnecessary. Missing documentation Invalid treatment plan.	Moderate	$0.00	$825.18	$825.18	$0.00
61	T01 - Mental Health Rehab Services	Telemedicine MHRS FY2020	Final determination reasons: insufficient documentation	Moderate	$0.00	$218.43	$218.43	$0.00
62	X04 - Clinic, Adlt Alc/Subst Abuse	Investigation SUD FY2021	Reasons for Failed Medicaid claims: insufficient documentation; Encounter note does not substantiate claim; false documentation; service improperly billed.	Moderate	$0.00	$1,920.33	$1,920.33	$0.00
63	T01 - Mental Health Rehab Services	New Provider MHRS 2020	Reasons for failed claims: missing documentation; medically unnecessary; service improperly billed; insufficient documentation.	Moderate	$0.00	$6,339.12	$6,339.72	-$0.60
64	T01 - Mental Health Rehab Services	Telemedicine MHRS 2020	Final Determination Reason: Insufficient documentation	Moderate	$0.00	$234.29	$234.29	$0.00
65	T01 - Mental Health Rehab Services	Telemedicine MHRS 2020	DBH FAILED CLAIMS AUDIT	Moderate	$0.00	$97.08	$97.08	$0.00
66	T01 - Mental Health Rehab Services	Telemedicine MHRS 2020	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$0.00	$364.05	$364.05	$0.00
67	T01 - Mental Health Rehab Services	New Provider MHRS 2020	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$0.00	$1,067.88	$1,067.88	$0.00
68	T01 - Mental Health Rehab Services	New Provider MHRS 2020	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$0.00	$2,392.18	$2,392.18	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
69	T01 - Mental Health Rehab Services	Telemedicine MHRS 2020	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$0.00	$138.72	$138.72	$0.00
70	W01 - IDD Waiver	Beneficiary receiving Companion Services S5135 U1, Respite T1005 U4, In Home Supports 99509 U4- all in the same day	Medicaid Repayment Demand for 2019 MHRS Focused New Provider Claims Audit	Moderate	$10,181.55	$10,181.55	$10,181.55	$0.00
71	W01 - IDD Waiver	Supported Living T2016 UA (*expanded audit from previously conducted audit) Audit DOS 4/18/21 to 9/18/21 - 2 with exclusion of DOS from 6/1/2021 to 6/30/2021	Medicaid Repayment Demand for 2020 MHRS Focused New Provider Claims Audit	Moderate	$58,097.72	$58,097.72	$3,546.00	$26,240.41
72	T01 - Mental Health Rehab Services	Telemedicine MHRS FY2020	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$0.00	$558.21	$558.21	$0.00
73	T01 - Mental Health Rehab Services	Annual MHRS 2019	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$0.00	$1,371.37	$1,371.37	$0.00
74	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Local Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$873.72	$873.72	$873.72	$0.00
75	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$242.70	$242.70	$242.70	$0.00
76	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2019 MHRS Focused New Provider Claims Audit	Moderate	$194.16	$194.16	$194.16	$0.00
77	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$97.08	$97.08	$97.08	$0.00
78	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2021 MHRS Focused Investigation Claims Audit	Moderate	$291.24	$291.24	$291.24	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
79	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$1,262.04	$1,262.04	$1,262.04	$0.00
80	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused New Provider Claims Audit	Moderate	$4,854.00	$4,854.00	$4,854.00	$0.00
81	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$291.24	$291.24	$291.24	$0.00
82	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$194.16	$194.16	$194.16	$0.00
83	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$679.56	$679.56	$679.56	$0.00
84	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$97.08	$97.08	$97.08	$0.00
85	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Insufficient documentation: Encounter note does not substantiate claim. Insufficient documentation. Encounter note does not substantiate claim.	Moderate	$4,012.21	$4,012.21	$4,012.21	$0.00
86	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2020 MHRS Focused Telemedicine Claims Audit	Moderate	$24.27	$24.27	$24.27	$0.00
87	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medicaid Repayment Demand for 2021 MHRS Focused Investigation Claims Audit	Moderate	$1,917.34	$1,917.34	$1,917.34	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
88	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Meyers & Stauffer sent Proposed notice, one of the prov. failed. due to encounters provided with Place of Service = 21	Moderate	$218.43	$218.43	$218.43	$0.00
89	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Medically unnecessary Invalid treatment plan False Documentation	Moderate	$2,904.71	$2,904.71	$2,904.71	$0.00
90	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Missing Documentation. Service improperly billed. Insufficient documentation.	Moderate	$970.80	$970.80	$970.80	$0.00
91	T01 - Mental Health Rehab Services	DBH FAILED CLAIMS AUDIT	Insufficient documentation Medically unnecessary	Moderate	$315.51	$315.51	$315.51	$0.00
92	X02 - Clinic, Mental Health	DBH	Insufficient documentation Service improperly billed	Limited	$0.00	$388.32	$388.32	$0.00
93	H00 - Pharmacy, Retail	Recoupment	Recoupment	Moderate	$30,435.33	$3.15	$3.15	$0.00
94	H00 - Pharmacy, Retail	Recoupment	Recoupment $0 balance	Moderate	$26.57	$26.57	$26.57	$0.00
95	T01 - Mental Health Rehab Services	Annual MHRS 2019	Recoupment $0 balance	Moderate	$2,742.51	$2,742.51	$2,742.51	$0.00
96	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail: Insufficient documentation - 16% Medically unnecessary - 9% Service improperly billed - 4% False documentation - 3% Encounter note does not substantiate claim - 2% Invalid treatment plan - 1%	Moderate	$342.30	$342.30	$342.30	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
97	W01 - IDD Waiver	Supported Living Services T2016 UA	Reasons for final fail: Insufficient documentation - 5% Service improperly billed - 1%	Moderate	$21,023.85	$21,023.85	$12,000.00	$9,023.85
98	U08 - EHR Incentive Payment Financial	EHR Post payment audit PY2020 MU	Final letter sent to prov. 5/27/2022	Limited	$8,500.00	$8,500.00	$7,791.63	$708.37
99	W01 - IDD Waiver	Companion Services, Behavioral Services, Supported Living Services	Claims that lacked documentation to support billing. Discrepancy in documentation sources to support billing. Progress notes appear to be a duplicate of another date of service. Overlapping of services between Companion services and Behavioral Support services. Claims with insufficient documentation to support billing.	Moderate	$34,298.41	$30,373.41	$22,780.08	$7,593.33

Q21 - Audit Details
FY 2023

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
1	H00 - Pharmacy, Retail	Pharmacy	Lack of documentation to support billing and reimbursement for pharmacy services	Moderate	$0.00	$3,500.00	$3,500.00	$0.00
2	U08 - EHR Incentive Payment Financial	EHR Incentive	Recoupment of $8,500.00 will be sent to prov. 100% of the encounters took place in a hospital setting, and therefore they have exceeded the 90% threshold and are ineligible to receive an incentive payment	Limited	$8,500.00	$8,500.00	$3,541.65	$4,958.35

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
3	T01 - Mental Health Rehab Services	MHRS Services	Insufficient documentation. Medically Unnecessary Service Improperly billed. Encounter Note does not substantiate claim	Moderate	$0.00	$1,970.23	$656.76	$1,313.47
4	T01 - Mental Health Rehab Services	Annual MHRS 2019	Insufficient documentation. Medically Unnecessary Services improperly billed. Note does not support billing. False Documentation. Missing documentation.	Moderate	$0.00	$1,770.84	$1,475.70	$295.14
5	T01 - Mental Health Rehab Services	MHRS Services	False Documentation. Missing documentation. Invalid treatment. Insufficient documentation.	Moderate	$0.00	$2,543.89	$2,331.89	$212.00
6	T01 - Mental Health Rehab Services	MHRS Services	Insufficient documentation. Missing documentation. Invalid treatment. Services improperly billed.	Moderate	$0.00	$3,190.88	$2,393.19	$797.69
7	T01 - Mental Health Rehab Services	MHRS Services	Invalid treatment. Insufficient documentation. Medically Unnecessary. False Documentation.	Moderate	$0.00	$2,834.19	$2,361.80	$472.39
8	T01 - Mental Health Rehab Services	MHRS Services	Insufficient documentation. Services improperly billed. Missing documentation.	Moderate	$0.00	$3,013.68	$753.42	$2,260.26
9	T01 - Mental Health Rehab Services	MHRS Services	Insufficient documentation. False Documentation Invalid treatment.	Moderate	$0.00	$1,728.38	$1,440.30	$288.08
10	T01 - Mental Health Rehab Services	MHRS Services	Insufficient documentation. Medically Unnecessary. Services improperly billed. Note does not support billing.	Moderate	$0.00	$1,237.22	$1,031.00	$206.22
11	T01 - Mental Health Rehab Services	MHRS Services	Insufficient documentation. Medically Unnecessary. Services improperly billed.	Moderate	$0.00	$2,955.99	$1,231.65	$1,724.34
12	T01 - Mental Health Rehab Services	Annual MHRS 2019	Invalid treatment. Missing documentation.	Moderate	$800.91	$800.91	$800.91	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
13	T01 - Mental Health Rehab Services	MHRS Services	Missing documentation. Invalid treatment.	Moderate	$2,400.30	$0.00	$2,400.30	$0.00
14	T01 - Mental Health Rehab Services	Annual MHRS 2019	Insufficient documentation. Medically Unnecessary. Missing documentation. Invalid treatment	Moderate	$0.00	$2,318.71	$2,318.71	$0.00
15	T01 - Mental Health Rehab Services	Annual MHRS 2019	DBH Failed Claims	Moderate	$0.00	$1,215.93	$709.31	$506.62
16	H00 - Pharmacy, Retail	PBM- Pharmacy Audit Recovery.	PBM- Audit Recovery Completed on 11/7/2022	Moderate	$23,457.23	$22,676.55	$6,784.57	$0.00
17	T01 - Mental Health Rehab Services	Focused Telemedicine MHRS 2020	Final Determination Reason: Insufficient documentation	Moderate	$0.00	$72.81	$72.81	$0.00
18	W01 - IDD Waiver	Supported Living T2016 UA (*expanded audit from previously conducted audit) Audit DOS 4/18/21 to 9/18/21 - 2 with exclusion of DOS from 6/1/2021 to 6/30/2021	• Claims that lacked documentation to support billing • Discrepancy in documentation sources to support claim • Billing when the person is not receiving direct care staff support from a provider	Moderate	$58,097.72	$29,786.41	$9,219.60	$17,020.81
19	W01 - IDD Waiver	Respite (T1005 U4) services provided more than 2880 units	Reasons for final fail: • Insufficient Documentation – 22 %, Encounter note does not substantiate claims 44% and Invalid Care plan 33%ts in a calendar year (CY 21) • Start /end time of each shift is missing on service documentation • Claims that lacked documentation to support billing • Discrepancy in documentation sources to support billing • PN appears to be a duplicate of another DOS/ another DSP	Moderate	$3,103.38	$3,103.38	$3,103.38	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
20	T01 - Mental Health Rehab Services	Annual MHRS 2019	Final Result fail reasons: 4- Insufficient documentation 5- Encounter note does not substantiate claim 6- Medically unnecessary 2- False documentation 11- Service improperly billed 7- Missing documentation	Moderate	$0.00	$2,827.86	$2,120.94	$706.92
21	W01 - IDD Waiver	Companion (S5135 U1 CR), Behavioral Support (H0025 U7 CR), Supported Living (T2016 U6 HI CR)	-Start /end time of each shift is missing on service documentation - Signature of the Direct Support Professional (DSP) not included on service documentation -Claims that lacked documentation to support billing - Claims with service staffing ratio not maintained per authorization/other documents - Discrepancy in documentation sources to support billing -PN appears to be a duplicate of another DOS/ another DSP Other observations: -DSP providing more than one service at a time	Moderate	$32,691.44	$32,691.44	$32,691.44	$0.00
22	H00 - Pharmacy, Retail	Audit Documents Review to Support and Reimbursement		Moderate	$675.69	$675.69	$675.69	$0.00
23	H00 - Pharmacy, Retail	Contracted Audit with Magellan		Moderate	$4,315.69	$498.53	$498.53	$0.00
24	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail: Insufficient documentation - 39% Medically unnecessary - 4% False documentation - 1% Invalid treatment plan - 1% Missing documentation - 1%	Moderate	$3,716.88	$3,716.88	$619.48	$3,097.40

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
25	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail: Invalid treatment plan - 4% Insufficient documentation - 2% Encounter note does not substantiate claim - 2%	Moderate	$1,781.10	$1,781.10	$296.86	$1,484.24
26	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail: Insufficient documentation - 12% Encounter note does not substantiate claim - 4% Invalid treatment plan - 3% Medically unnecessary - 1%	Moderate	$1,647.01	$1,647.01	$274.50	$1,372.51
27	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail: Insufficient documentation - 22% Service improperly billed - 4% Medically unnecessary - 3% Encounter note does not substantiate claim - 2% Invalid treatment plan - 1%	Moderate	$2,681.00	$2,681.00	$446.82	$2,234.18
28	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail: Insufficient documentation - 20% Service improperly billed - 3% Encounter note does not substantiate claim - 2% False documentation - 1%	Moderate	$3,254.36	$3,254.36	$271.20	$2,983.16
29	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail: Insufficient documentation - 6% Encounter note does not substantiate clam - 2% Service improperly billed - 2% Missing documentation - 1%	Moderate	$1,156.74	$1,156.74	$192.80	$963.94
30	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail:Invalid treatment plan - 37%Missing documentation - 7%Insufficient documentation - 5%Encounter note does not substantiate claim - 1%	Moderate	$5,148.14	$5,148.14	$1,287.03	$3,861.11

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
31	T01 - Mental Health Rehab Services	Annual Health Homes 2019	Reasons for final fail: Insufficient Documentation - 10% Medically Unnecessary - 3% False Documentation - 1%	Moderate	$836.11	$836.11	$836.11	$0.00
32	T01 - Mental Health Rehab Services	Annual MHRS 2019	Reasons for final fail: Insufficient Documentation – 22 %, Encounter note does not substantiate claims 44% and Invalid Care plan 33%	Moderate	$1,355.00	$1,355.00	$564.60	$790.40
33	X02 - Clinic, Mental Health	Annual MHRS 2019	Reasons for final fail: Insufficient documentation - 5% Encounter note does not substantiate claim - 5% Service improperly billed - 1%	Limited	$1,308.24	$1,308.24	$327.06	$981.18
34	W01 - IDD Waiver	Supported Living Services T2016 UA	• Claims that lacked documentation to support billing • Discrepancy in document sources to support billing • Billing when the person is not receiving direct care staff support from a provider • Progress notes appear to be a duplicate of another date of service • Progress notes does not contain progress in meeting goals in ISP & Plan of Care	Moderate	$21,023.85	$21,023.85	$6,500.00	$2,523.85
35	U08 - EHR Incentive Payment Financial	EHR Post payment audit PY2020 MU	EHR Post payment audit PY2020 MU	Limited	$8,500.00	$8,500.00	$708.37	$0.00

Report Index	Provider Type	Audit Focus	Summary of Identified Deficiencies (Brief)	DHCF Identified Risk Level	Sum of Proposed Recoupment Amount	Sum of Sum Final Recoupment Amount	Sum of Amount Recovered Current Fiscal year	Sum of Recoupment Balance Due
36	W01 - IDD Waiver	Companion Services, Behavioral Services, Supported Living Services	Claims that lacked documentation to support billing. Discrepancy in documentation sources to support billing. Progress notes appear to be a duplicate of another date of service. Overlapping of services between Companion services and Behavioral Support services. Claims with insufficient documentation to support billing.	Moderate	$34,298.41	$30,373.41	$7,593.33	$0.00

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

22. Please identify each incident of Medicaid abuse or fraud investigated in FY22 and to date in FY23 and any associated sanction/penalty. What problem areas or patterns have been discovered regarding fraud in the District's Medicaid program? Please identify providers and amounts recouped for each, including any supporting documentation.

Response:
DHCF's Division of Program Integrity (DPI) includes an Investigations Branch, a Surveillance Utilization Review Section (SURS), and a Data Analytics Branch. Although the Investigations Branch primarily focuses on the investigation of fraud based on information or data mining obtained from various sources and SURS focuses on audits of providers to ensure proper billing utilization, the branches work in conjunction with each other. These joint efforts can include combined data-mining efforts, joint efforts on specific cases (such as an audit based on statistical sampling to identify trends and a follow-up or concurrent investigation to determine if there is a related credible allegation of fraud), and referrals from one branch to the other when an audit identifies potential fraud, or an investigation determines the case involves abuse. In addition, DPI oversees program integrity activities conducted by the District's Managed Care Organizations (including audits and investigations), conducts information sharing and coordination with the Department of Behavioral Health (DBH) and Department on Disability Services (DDS) concerning program integrity issues, and completes collaboration with law enforcement agencies.

DHCF investigated or continues to investigate **157** cases of alleged Medicaid fraud in FY 2022. In FY 2022, **10** cases were referred to law enforcement. As of January 20, 2023, DHCF referred an additional **3** cases to law enforcement and investigated or continues to investigate **10** additional cases of alleged Medicaid fraud in FY 2023 (for a total of **167** cases investigated or continuing to be investigated across FY22 and FY23 to date). Please refer to **Table 1** below for more detail on the investigative cases.

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

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

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

- 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 the Medicaid program enrollment process;
- Providers submitting claims for services during periods professional license was suspended; and
- Beneficiary involvement in fraud schemes, including falsification of medical conditions, falsification of records, and providing/accepting kickback payments or other illegal remuneration.

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

Table 1

Provider Type	Date Referred	Referred To	STATUS
Behavioral Health	3/8/2022	MFCU & L.E.	Pending Criminal Investigation
Behavioral Health	3/8/2022	MFCU & L.E.	Pending Criminal Investigation
Behavioral Health	5/18/2022	MFCU & L.E.	Pending Criminal Investigation
Behavioral Health	5/18/2022	MFCU & L.E.	Pending Criminal Investigation
Behavioral Health	5/18/2022	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	6/30/2022	MFCU & L.E.	Pending Criminal

			Investigation
Personal Care Services	6/30/2022	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	9/29/2022	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	9/29/2022	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	9/30/2022	MFCU & L.E.	Pending Criminal Investigation
Behavioral Health	1/06/2023	MFCU & L.E.	Pending Criminal Investigation
Mental Health	1/20/2023	MFCU & L.E.	Pending Criminal Investigation
Personal Care Services	1/20/2023	MFCU & L.E.	Pending Criminal Investigation
Pharmaceutical	--	--	On-going
Personal Care Services	--	--	On-going
Pharmacy	--	--	On-going
Dental	--	--	On-going
Behavioral Health	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Participant Directed Services	--	--	On-going

Behavioral Health	--	--	On-going

Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Pharmaceutical	--	--	On-going
Behavioral Health	--	--	On-going
Transportation	--	--	On-going
Participant Directed Services	--	--	On-going
Dental	--	--	On-going
Participant Directed Services	--	--	On-going
Nurse	--	--	On-going
Behavioral Health	--	--	On-going
Personal Care Services	--	--	On-going
Behavioral Health	--	--	On-going
Physician	--	--	On-going
Behavioral Health	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
DENTAL	--	--	On-going
Personal Care Services	--	--	On-going
DENTAL	--	--	On-going
DENTAL	--	--	On-going
DENTAL	--	--	On-going
DENTAL	--	--	On-going
Behavioral Health	--	--	On-going
DENTAL	--	--	On-going
Personal Care Services	--	--	On-going
DENTAL	--	--	On-going
Personal Care Services	--	--	On-going
Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
DENTAL	--	--	On-going
Physician	--	--	On-going

Mental Health	--	--	On-going
Mental Health	--	--	On-going

Physician	--	--	On-going
Behavioral Health	--	--	On-going
DME	--	--	On-going
Mental Health	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
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Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Pharmacy	--	--	On-going
Behavioral Health	--	--	On-going
DENTAL	--	--	On-going
Behavioral Health	--	--	On-going
DME	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Behavioral Health	--	--	On-going
Behavioral Health	--	--	On-going
Behavioral Health	--	--	On-going
DENTAL	--	--	On-going
DENTAL	--	--	On-going
Behavioral Health	--	--	On-going
Personal Care Services	--	--	On-going
DENTAL	--	--	On-going
Behavioral Health	--	--	On-going

Behavioral Health	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Behavioral Health	--	--	On-going

Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
DENTAL	--	--	On-going
Personal Care Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Behavioral Health	--	--	On-going
DENTAL	--	--	On-going
DME	--	--	On-going
Behavioral Health	--	--	On-going
DENTAL	--	--	On-going
Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
DME	--	--	On-going
Behavioral Health	--	--	On-going
Participant Directed Services	--	--	On-going
DENTAL	--	--	On-going
Ophthalmology	--	--	On-going
Behavioral Health	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Behavioral Health	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Participant Directed Services	--	--	On-going

Psychologist	--	--	On-going
Personal Care Services	--	--	On-going
DENTAL	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Participant Directed Services	--	--	On-going
Personal Care Services	--	--	On-going
Personal Care Services	--	--	On-going
Mental Health	--	--	On-going
Mental Health	--	--	On-going
Participant Directed Services	--	--	On-going
DME	--	--	On-going
DME	--	--	On-going
DME	--	--	On-going
Pharmaceutical	--	--	On-going
Disability Services	--	--	On-going
Disability Services	--	--	On-going
LAB	--	--	On-going
Physician	--	--	On-going
DENTAL	--	--	On-going
Personal Care Services	--	--	On-going
LAB	--	--	On-going
Behavioral Health	--	--	On-going
Disability Services	--	--	On-going
DENTAL	--	--	On-going

TOTAL 167

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

23. Federal regulations require an annual program independent review of the Medicaid Managed Care program. Provide a copy of the review for FY 2022, or the most recent review conducted. Also include the following information:

a. The agency's interpretation of the key findings and conclusions;
b. Action plans for addressing the review's key findings and conclusions;
c. Narrative text about how the reviews will proceed under the new MCO contracts.

Response:
Federal regulations require an annual independent program review of the Medicaid Managed Care program be performed by an External Quality Review Organization (EQRO). The EQRO conducts an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCO, or its contractors, furnish to Medicaid beneficiaries. The results of this independent external quality review (EQR) is compiled into the District of Columbia Medicaid Managed Care Annual Technical Report (ATR). The ATR is the public facing end-product of the annual EQR and must be made available on DHCF's website and upon request either in print or electronically. The ATR must include:

1. The results of the EQR-related activities.
2. The EQRO's assessment of each MCO's strengths and weaknesses related to quality, timeliness and access.
3. Recommendations for: improving the quality of health care services furnished by each MCO; and how the DHCF can target goals and objectives in the District's quality strategy.
4. Comparative information about all MCOs.
5. An assessment how each MCO has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

The most recent review can be found here:
https://dhcf.dc.gov/publication/2021-district-columbia-annual-technical-report-atr

The ATR for FY 2022 will be available April 30, 2023.

a) The key findings and conclusions are summarized below. Each reflect that the District's MCO average fell short of meeting national benchmarks on measures relating to the effectiveness of care, access, and availability of services, preventive care utilization, and enrollee experience of care.

Findings
Performance Improvement Projects (PIPs) are a federal requirement intended to achieve significant improvement in measurement of quality performance with

objective indicators, as well as to generally sustain this improvement over time (42 CFR §438.330). Each of the MCOs conducted two PIPs and reported performance measure results in measurement year 2020.

1. The Comprehensive Diabetes Care PIP (CDC) measured the percentage of enrollees 18-75 years of age with diabetes (type 1 and type 2) who had each of the following during the measurement year: Hemoglobin A1c (HbA1c) Testing; HbA1c Poor Control (>9%); HbA1c Control (<8%); HbA1c Control (<7%) for a Selected Population; Eye Exam (Retinal) Performed; Medical Attention for Nephropathy; Blood Pressure Control (< 140/90 mm Hg)

   This PIP was in its third measurement year. MCO weighted averages were worse than baseline performance for all measures. This decline in performance was likely influenced by the COVID-19 public health emergency (PHE).

2. The Maternal Health PIP measured the percentage of deliveries of live births that received a prenatal care visit as a member of the MCO in the first trimester, on the enrollment start date or within 42 days of enrollment in the MCO (Timeliness of Prenatal Care). The measure also assesses the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery (Postpartum Care).

   MCOs reported their first remeasurement results with PIP validation scores ranging from 54% to 96%. This broad range was likely due to the COVID-19 PHE. However, all MCOs demonstrated improvement in the Timeliness of Prenatal Care measure.

Performance Measure Validation (PMV) evaluates the accuracy and reliability of measures produced and reported by the MCO and determines the extent to which the MCO followed specifications for calculating and reporting the measures. The first audit focused on validating the accuracy of reported PIP measures and the second audit focused on validating the accuracy of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures.

Information Systems Capabilities Assessments determined MCOs had appropriate systems in place to process accurate claims and encounters, which were used to calculate performance measure rates. The MCOs received overall PMV ratings of 100% for the PIP measures and 95% to 100% for the EPSDT measures. All measures were assessed as "reportable."

The EQRO conducts an **Operational Systems Review (OSR)** to assess MCO compliance with federal and DHCF managed care program requirements, which may

impact the quality, timeliness, or accessibility of health care services provided to Medicaid enrollees. This comprehensive review determines compliance on the OSR Standards (i.e., core requirements that have to be met in order to deliver services to Medicaid enrollees): Information Requirements (42 CFR §438.10); Disenrollment Requirements and Limitations (42 CFR §438.56); Enrollee Rights and Protections (42 CFR §438.100-114); MCO Standards (42 CFR §438.206-242); Quality Assessment and Performance Improvement Program (42 CFR §438.330); and Grievance and Appeal System (42 CFR §438.402-424).

MCO scores ranged from 96% to 99%. All MCOs were required to develop and implement corrective action plans (CAPs) to address noncompliant elements and components of the standards, most of which related to the Grievance and Appeal System standard. MCO overall weighted scores demonstrated improvement in compliance with federal and DHCF program requirements during the FY 2021 audit compared to the two (2) previous OSR reviews.

Network Adequacy Validation (NAV) assessed that the MCOs have robust provider networks demonstrating at least 99% compliance with geographic and provider-to-enrollee requirements. During 2021, MCO-access to timely provider appointments was generally lower, with improvement in the MCO average for adult routine appointments only. Performance was likely influenced by the COVID-19 PHE.

Accuracy of the MCOs' Provider Directory remains an area of improvement. All MCOs should continue efforts to improve the reliability of provider directory content ensuring enrollees have access to accurate provider information. As part of the Centers for Medicare & Medicaid Services (CMS) mandate to implement a provider directory application programming interface (API), each MCO is working with CRISP as the District's Health Information Exchange (HIE) to assist them and their provider network in maintaining the accuracy of the directory.

Encounter Data Validation (EDV) is a medical record review to determine the accuracy of encounter data (i.e., MCO claims submitted to the DHCF). As payment methodologies evolve and incorporate value-based payment elements, collecting complete and accurate encounter data is critical. The audit concluded an overall high level of encounter data accuracy, meaning medical record documentation supported the encounters' associated diagnosis and procedure codes. MCO performance ranged from 88% to 98%, with an average of 95%, exceeding the target of 90%, established by DHCF for the first year of review. Insufficient medical record documentation at the provider site most frequently contributed to noncompliance.

DHCF also reviews performance on:

- Healthcare Effectiveness Data and Information Set (HEDIS®), which was developed and is maintained by the National Committee for Quality Assurance (NCQA). Each MCO is required to be accredited by NCQA as part of their contract with the District and is mandated to report HEDIS measures to maintain accreditation. HEDIS data are collected through a combination of surveys, provider medical record audits and insurance claims data.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a consumer survey that measures the satisfaction of enrollees with the MCO, provider accessibility, patient/provider relationship and communication.

HEDIS and CAHPS performance measure results, on average, did not meet the national average benchmarks.

Conclusion
The EQRO evaluated MCO compliance in providing Medicaid managed care enrollees with quality and timely access to care and concluded, on average, MCOs are meeting requirements and demonstrating their commitment to quality improvement. In most instances, stakeholders can have high confidence in their compliance with federal regulations and DHCF contract requirements.

Considerations must be made for the challenges posed by the COVID-19 PHE. Reduced access to timely routine and urgent provider appointments, surgeries, and other physician and hospital services, combined with fear of exposure to the virus, led to a significant drop in access to care. These factors unduly impacted the MCOs regarding their PIP, HEDIS and CAHPS performance metrics. For example, provider offices were inaccessible for medical record audits to supplement claims data; and due to the limitations of attaining appointments, the sample sizes for surveys regarding provider performance would be severely reduced.

b) Opportunity exists to improve results in the areas of behavioral health and maternal health. These areas support goals and objectives identified in DHCF's Medicaid Managed Care Quality Strategy. In FY 2023, DHCF is continuing the maternal health PIP and initiating a new PIP targeting enrollee access to behavioral health services, to achieve the DHCF goal of improved access to quality, whole-person care.

DHCF is continuing to closely monitor MCO performance and compliance utilizing the enhanced quality improvement approach, and as needed, holding MCOs accountable through progressive discipline of corrective action plans, enhanced

monitoring which requires monthly reporting on activities to resolve noncompliance, and intermediate sanctions.

DHCF will amend its quality strategy and add specific objectives and strategies to address health equity and behavioral health. This will further enhance DHCF's efforts to ensure access to quality, whole-person care; improve management of chronic conditions; improve population health; and ensure high-value, appropriate care for all Medicaid managed care enrollees.

c) The reviews will continue as they have in past years as the external quality review process must follow the 42 CFR §438.350. DHCF contracted with an external quality review organization (EQRO) in August 2022 for a five (5) year term to conduct annual, independent reviews of the MCOs. To meet these requirements, the EQRO, evaluates each MCO's compliance with federal and DC-specific requirements (i.e., the MCO contract and any applicable DC regulations) in a manner consistent with the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols (*Updated in 2022:* https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305)

The EQRO will conduct the following EQR activities for the new MCO contracts:

1. Performance Improvement Project (PIP) Validation
2. Performance Measure Validation (PMV)
3. Compliance Review also known as Operational Systems Review (OSR)
4. Network Adequacy Validation (NAV)
5. Encounter Data Validation (EDV)

In accordance with 42 CFR §438.364(a). the EQRO will produce a detailed technical report describing the method that data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCO. The EQRO will identify MCOs' strengths and weaknesses relating to quality, access, and timeliness of care provided to managed care enrollees and include recommendations for improvement.

Consistent with our policies and procedures, DHCF will take appropriate action should the MCO not remediate non-compliance with the federal or District regulatory requirements. This includes, issuance of corrective action plans (CAPs); implementation of enhanced monitoring within the program area where the finding occurred; and in extreme cases, initiation of intermediate sanctions per 42 CFR §438.700.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

24. 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 FY22 and FY23, to date, regarding:

a. Services provided and eligibility requirements in FY22 or FY23; and
b. Reimbursement rates/methodologies in FY22 or FY23.

Response:

a. Services provided and eligibility requirements in FY22 or FY23

- 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 expand up to a 10-year period consisting of nearly a five-year base period and a five-year option period. Implementation of BH services will begin in FY24, during the second year of the base period. Staff from the Department of Behavioral Health (DBH) and DHCF have partnered to conduct training and discussions necessary to ensure readiness by BH providers, contracted MCOs, and other entities critical to the integration of BH services into managed care.

- Beginning in FY22, doula services were added as a covered service for Medicaid, Alliance and ICP beneficiaries. All pregnant women covered under the State Plan will have access to a total of 12 doula visits across the prenatal, childbirth, and postpartum periods.

  Services covered during the perinatal and birthing period include:
  - Perinatal counseling and education, including infant care, to prevent adverse outcomes;
  - Labor support, including the development of a birth plan;
  - Coordination with community-based services, to improve beneficiary outcomes; and
  - Other nonclinical activities to support the beneficiary, consistent with District Law.
  - Postpartum doula services include:
  - Visits to provide basic infant care;
  - Accompanying the beneficiary to a clinician visit;
  - Lactation support;
  - Emotional and physical support;

- Selfcare; and
- Other nonclinical activities to support the beneficiary, consistent with District Law.

- In FY22, a new five-year contract was re-awarded to a single MCO, Health Services for Children with Special Needs (HSCSN), to provide healthcare services to children and young adults who voluntarily enroll in the program.

- In 2019, CMS approved an 1115 waiver to expand behavioral health services to DC Medicaid beneficiaries. As part of the 1115 Behavioral Health waiver, Medicaid was allowed to reimburse Residential Treatment Facility (RTF) providers for the substance abuse service(s) that they provide. The Managed Care Organizations (MCOs) are only allowed to reimburse services up to 15 days, per CMS' Managed Care Rule. When services are necessary beyond 15 days, the Quality Improvement Organization (QIO) is contracted to ensure that services continue at the RTF. DHCF and DBH implemented the service of the QIO to conduct the reviews in February 2022. The QIO is also responsible for ensuring that the Fee-for-service (FFS) beneficiaries receive medically necessary services in an RTF from admission to discharge. The QIO provides initial reviews for FFS and concurrent reviews for FFS and MCO beneficiaries. The MCOs continue to follow the patient during the RTF stay to ensure that post-discharge services are in place.

b. Reimbursement rates/methodologies in FY22 or FY23

- Risk-Corridor

  In FY22, DHCF implemented 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 continuation of the risk corridor will be reassessed as needed. Separate risk corridors will apply to the DCHFP and Alliance programs. Medical claims audits will begin in Jan 2023 to assist in analyses for determination of the risk-mitigation outcomes. Applicable payments pertaining to FY22, either to MCOs or DHCF, are targeted to occur in April 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

25. For each waiver program, please provide a description of and reason for any changes or planned changes in FY 2022 and FY 2023, to date, and:

a. FY 2022 and FY 2023, to date, 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 18 for aggregated budget and spending information for FY22 and the first quarter of FY23 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.

All three 1915(c) Medicaid waivers operated by the District were amended or renewed during FY22 or shortly thereafter. The EPD Waiver was renewed for another five-year period, effective February 7, 2022. The renewal incorporated changes allowing the District's Dual Choice (Dual Eligible Special Needs Plan, or D-SNP) program to cover EPD Waiver services and perform certain waiver functions, as well as changes to improve the performance and operations of the Participant-Directed Services (PDS) program in the EPD Waiver (also known as Services My Way).

The EPD Waiver was amended effective January 1, 2023 to include authority for supplemental payments for direct care workers. The IDD Waiver was renewed for another five-year period effective October 1, 2022. This renewal incorporated changes to expand eligibility criteria, add new services, and include authority for supplemental payments for direct care workers. The Individual and Family Supports (IFS) Waiver was amended effective October 1, 2022 and this amendment added expanded eligibility criteria, participant-directed services and authority for supplemental payments for direct care workers.

a. Please see "Attachment 1 to Q25" for FY22 and FY23, to date, for enrollment by gender for the EPD Waiver, "Attachment 2 to Q25" for FY22 and FY23, to date, for enrollment by gender for the IDD Waiver, and "Attachment 3 to Q25" for FY22 and FY23, to date, for enrollment by gender for the IFS Waiver.

Please note that FY23 enrollment data should be considered preliminary. As with reports based on claims data, DHCF employs a three-month reporting lag for enrollment data to ensure accuracy and completeness of the data. DHCF posts updated enrollment reports, which include EPD and IDD Waiver enrollment, monthly on the DHCF website: https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports.

b. ***IDD Waiver***: The IDD Waiver has a capacity of 1,943 for Waiver Year 5 (October 1, 2022

through September 30, 2023). As of January 27, 2023, 1,873 individuals were enrolled in the IDD Waiver. There is no waiting list.

IFS Waiver: The capacity for the IFS waiver is 90 for Waiver Year 3 (October 1, 2022 through September 30, 2023). This waiver has 10 enrollees as of January 27, 2023.

EPD Waiver: The enrollment cap for the number of unduplicated participants in Waiver Year 6 (February 7, 2022 through February 6, 2022) is 6,060 and for Year 7, 6,160. The enrollment is 5,473 as of January 27, 2023. There is no waiting list at present.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

26. Please provide a list of all State Plan Amendments (SPAs) or demonstration projects submitted to CMS for approval in FY22 or planned for submission in FY23 and FY24. 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: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
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
21-0007	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: 3.30.22 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: 7.14.21 Approved: Under Review Proposed Effective Date: 9.27.21	N/A	FY21: $0 FY22: $0

Table 1: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
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: 4.26.22 Effective: 1.1.22	Provides certain behavioral health services under the State Plan.	FY22: $4,953,116 FY23: $6,999,133
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: 5.23.22 Effective: 1.1.22	Establishes a new service under State Plan.	FY21: $310,219 FY22: $431,412
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: 2.7.22 Effective: 2.1.22	N/A	FY22: $0 FY23: $0

Table 1: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
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: 3.21.22 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
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: 3.2.22 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: 1.24.22 Effective: 12.31.21	N/A	FY22: $0 FY23: $0

Table 1: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
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: 3.18.22 Effective: 1.1.21	N/A	FY21: $0 FY22: $0
21-0021	Disproportionate Share Hospital (DSH) Payment	Permits the District 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: 3.1.22 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: 2.7.22 Effective: 2.7.22	N/A	FY22: $248,204,619 FY23: $315,747,914
22-0001	Postpartum Coverage Extension	Provides twelve (12) months of continuous postpartum coverage to individuals enrolled in the District's Medicaid Program	Submitted: 4.1.22 Approved: 6.16.22 Effective: 4.1.22	Extends coverage period for currently covered services.	FY22: $305,849 FY23: $404,349
22-0002	Qualified Clinical Trials	Adds coverage for routine patient costs incurred during qualified clinical trials to the State Plan, as required by the Consolidated Appropriations Act, 2021, Division CC, Title II, Section 210.	Submitted: 3.28.22 Approved: 5.2.22 Effective: 1.1.22	No coverage change: explicitly adds coverage that was an optional state policy choice (already adopted by the District) that is a now a requirement for all states from 1.1.22 forward.	FY22: $0 FY23: $0

Table 1: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
22-0003	Alternative Benefit Plan Update I	Updates the District's Alternative Benefit Plan Medicaid Expansion to be consistent with the State Medicaid Plan services, as federally required	Submitted: 3.31.22 Approved: 5.5.22 Effective: 1.1.22	N/A	FY22: $0 FY23: $0
22-0004	FY 23 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: 5.24.22 Approved: 8.22.22 Effective: 10.1.22	N/A	FY22: $0 FY23: $4,500,000
22-0005	Behavioral Health Rehabilitation Services Rates	Increases reimbursement rates for behavioral health rehabilitation services.	Submitted: 6.16.22 Approved: 8.3.22 Effective: 10.1.22	N/A	FY22: $2,319,000 FY23: $7,526,000
22-0006	Doula Services	Adds coverage for doula services under the State Plan.	Submitted: 7.22.22 Approved: 9.28.22 Effective: 10.1.22	Establishes a new service under the State Plan.	FY23: $578,586 FY24: $548,918
22-0007	Pharmacy Lock-In Program	At the request of the Centers for Medicare and Medicaid Services, removes language from the State Plan that details the number of days an individual identified for inclusion in the Pharmacy Lock-In Program has to submit a request for a hearing on the lock-in decision from the State Plan pages.	Submitted: 8.22.22 Approved: 10.21.22 Effective: 10.1.22	N/A	FY22: $0 FY23: $0

Table 1: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
22-0008	Vaccines for Children (VFC) Program	Allows pharmacies to receive reimbursement for the administration fee associated with providing VFC program vaccine and immunizations	Submitted: 8.23.22 Approved: 10.19.22 Effective: 9.1.22	N/A	FY22: $0 FY23: $0
22-0009	Alternative Benefit Plan Update II	Aligns the Alternative Benefit Plan with the District's Medicaid State Plan, as required under Section 1937 of the Social Security Act.	Submitted: 11.2.22 Approved: 12.8.22 Effective: 10.1.22	N/A	FY23: $0 FY24: $0
22-0010	Time-Limited Specialty Hospital Rebasing Delay	Delays the rebasing of per diem specialty hospital rates until the expiration of the COVID-19 public health emergency.	Submitted: 9.27.22 Approved: 11.30.22 Effective: 10.1.22	N/A	FY22: $0 FY23: $0
22-0011	Mandatory COVID-19 Services Under the American Rescue Plan Act	Authorizes the District of Columbia Medicaid Program to increase reimbursement to one hundred percent (100%) of the Medicare rates for COVID-19 treatments, COVID-19 PCR testing, COVID-19 vaccines and vaccine administration, and treatments for conditions that would seriously complicate COVID-19 treatment.	Submitted: 10.31.22 Approved: 1.27.23 Effective: 3.11.21 through the last day of the first calendar quarter beginning one (1) year after the last day of the COVID-19 federal public health emergency period.	N/A	FY22: $0 FY23: $3,614,571

Table 1: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
22-0012	Permanent COVID Vaccine Administration Rate Increase	Increases COVID-19 vaccine administration rates from 80% of the Medicare rate to 100% of the Medicare rate.	Submitted: 11.9.22 Approved: 2.7.23 Effective: 4.1.24 or the first (1st) day of the second (2nd) calendar quarter that begins one (1) year after the last day of the COVID-19 federal public health emergency period.	N/A	FY22: $3,311,044 FY23: $6,431,739
22-0013	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Allows nurse practitioners and physician assistants to complete the face-to-face encounter before DMEPOS are supplied to the beneficiary, without requiring supervision of a physician.	Submitted: 11.17.22 Approved: 12.5.22 Effective: 11.1.22	N/A	FY22: $0 FY23: $0
22-0014	Medicaid Eligibility	Make technical change to move covered eligibility groups from preprint State Plan pages into the MACPRO system, CMS's new system for capturing eligibility coverage groups. Also waives income eligibility restriction to disregard all income between statutory limit of 150% FPL and State Plan eligibility levels for all Medicaid 1915(i) services.	Submitted: 12.31.22 Approved: Under CMS Review Effective: 10.1.22	N/A	FY22: $0 FY23: $0

Table 1: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
DC-1766.R00.04	DC Individual and Family Support (IFS) Waiver Substantive Amendment	(1) Modifies the Developmental Disabilities (DD) criteria for waiver enrollment eligibility; (2) Adds new services (remote support services and individual-directed goods and services); (3) Sets payment rates for new services; (4) Adds the option for participant-directed services (PDS); (5) Modifies reimbursement methodology to include District-funded payment enhancements; and (6) Modifies the waiver enrollment process.	Submitted: 7.15.22 Approved: 9.27.22 Effective: 10.1.22		FY23: $2,145,615 FY24: $4,078,892
DC-1766.R00.05	DC Individual and Family Support (IFS) Waiver Technical Amendment	Makes a technical correction to align the Level of Care Criteria set forth in Appendix B-6-d: Evaluation/Reevaluation of Level of Care with the District's already approved institutional criteria.	Submitted: 12.13.22 Approved: 12.21.22 Effective: 10.1.22		FY23: $0 FY24: $0
DC.0307.R05.00	DC People with Intellectual and Developmental Disabilities (IDD) Waiver Renewal	Expands IDD waiver eligibility to people with developmental disabilities (DD) without a diagnosis of an intellectual disability (ID).	Submitted: 7.15.22 Approved: 9.27.22 Review Effective: 10.1.22		FY23: $257,885,176 FY24: $331,524,272
DC.0307.R05.01	DC People with Intellectual and Developmental Disabilities (IDD) Waiver Technical Amendment	Makes a technical correction to align the Level of Care Criteria set forth in Appendix B-6-d: Evaluation/Reevaluation of Level of Care with the District's already approved institutional criteria.	Submitted: 12.13.22 Approved: 12.21.22 Review Effective: 10.1.22		FY23: $0 FY24: $0

Table 1: SPAs/Waivers with a CMS Submission, Approval, or Effective Date in FY22 or FY23 (as of February 9, 2023)

TN	SPA/Waiver	Description	Status	Service Change	Cost/ (Savings)
0334.R05.00	DC Elderly and Persons with Physical Disabilities (EPD) Waiver Amendment	Modifies the criteria for involuntary termination of participant-directed service option to extend the period in which episodes of non-compliance may result in involuntary termination from twelve (12) months to thirty-six (36) months and allows supplemental provider payments and participant budget allocations.	Submitted: 9.30.22 Approved: 12.13.22 Effective: 1.1.23		FY23: $0 FY24: $0
DC-0307.R04.07	1915(c) Appendix K Amendment #7	Extends the date to pay out one-time supplemental payments to eligible waiver providers for Direct Support Professionals (DSPs); allows increased payment rates for DSP, RN and LPN services; allows increased per diem reimbursement rates to IDD waiver providers of Supported Living Daily and Residential Habilitation; and modifies the service limitations for EPD waiver beneficiaries currently enrolled in the *Service My Way* program to allow participant-directed PCA in excess of 16 hours per day (up to 24 hours), when authorized in the participant's person-centered service plan.	Submitted: 5.16.22 Approved: 7.1.22 Effective: 3.11.20 until six (6) months after the end of the federal COVID-19 public health emergency	N/A	N/A
DC-0307.R04.08	1915(c) Appendix K Amendment #8	Allows for the extension of the temporary increased payment rates for RN and LPN components of the rate methodology included within the per diem rate for Supported Living and Residential Habilitation services, retroactive to October 1, 2021, extending from September 30, 2022 to until six (6) months after the conclusion of the public health emergency.	Submitted: 8.23.22 Approved: 7.1.22 Effective: 3.11.20 until six (6) months after the end of the federal COVID-19 public health emergency	N/A	N/A

Table 2: FY23 and FY24 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).
Physician Supplemental Payments	Provides a supplemental payment in FY 24 to eligible an eligible group practice with at least five hundred (500) physicians that are members of the group.
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).
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.
Intensive Care Coordination	Adds coverage of intensive care coordination (ICC) services (also known as high-fidelity wraparound services) for children and youth with significant behavioral concerns
Federally Qualified Health Center (FQHC) Rebasing	Incorporates changes to the rebasing timeline for FQHCs into the Medicaid State Plan.
American Rescue Plan Act Section 9817 Supplemental Payments	Allows the use of ARPA funds to make supplemental provider payments for State Plan rehabilitative services, home health services, and personal care aide services to strengthen the Medicaid home and community-based workforce.
Recovery Audit Contractor Waiver	Extends the waiver of the requirement to have a recovery audit contractor, which expires on May 31, 2023.
Personal Needs Allowance	Increases the personal needs allowance for long term care beneficiaries to $100.
Enhanced Transplant Coverage	Adds coverage for pancreas and small bowel transplants.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

27. 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 FY22**.**

Table 1. PRTF Beneficiaries Served:

Delivery Management System	Beneficiaries Served	Percent of Total
Fee-for-Service	16	61%
AmeriHealth Caritas DC	2	8%
Medstar Family Choice	2	8%
CareFirst Community Health Plan/DC	1	4%
HSCSN	5	19%
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 FY22
Alabama	1
Arkansas	2
Florida	8
Georgia	1
Indiana	0
Pennsylvania	2
Arizona	0
Virginia	7
Maryland	3
Tennessee	2
Total	**26**

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 in FY22 was over 8 months (approximately 260 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.

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 all contracted MCOs -AmeriHealth Caritas DC, MedStar Family Choice, CareFirst Community Health Plan of DC and Health Services for Children with Special Needs (HSCSN) - along with 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, HSCSN, places

and monitors their enrollees in PRTFs. In addition, HSCSN collaborates with DBH as well as other agencies involved with their enrollees, in an effort to maximize the available resources to support monitoring HSCSN enrollees.

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	Total Number of Beneficiaries FY'22	Other Agency Involvement
Child and Family Services (CFSA)	9	DBH, NCCF, HSCSN, CSA
District of Columbia Public School (DCPS)	1	DBH, HSCSN
Department of Youth Rehabilitation Services (DYRS)	6	DBH, HSCSN, CareFirst, Beacon Health
Department of Behavior Health (DBH)	N/A	
DC Superior Court	3	DBH,
AmeriHealth Caritas	2	DBH, CSS
HSCSN	3	DBH
Core Service Agency (CSA)	1	DBH
MedStar Family Choice	2	DBH, Beacon Health
Office of the State Superintendent of Education (OSSE)	N/A	DBH, HSCSN

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

28. Please provide a status report on compliance with the terms and conditions set forth in the Salazar Consent Decree, specifically, outreach required 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 and Periodic Screening, Diagnosis, and Treatment (EPSDT) services 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 was aggressively litigated, resulting in numerous additional court orders which broadened 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. On March 31, 2022, the Court denied without prejudice the District's renewed motion to terminate but noted that the District has a compelling argument that prospective application of the Settlement Order is inequitable. Since then, at the Court's direction, the Parties have been engaged in settlement discussions to explore the possibility of an exit strategy.

In 2022, 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.

Most DC Medicaid beneficiaries are enrolled in Medicaid Managed Care Organizations (MCOs), including approximately 90% of the children insured by the Medicaid program. MCOs are responsible for ensuring there is an adequate provider network to serve the beneficiaries enrolled in their health plan; notifying beneficiaries of the services available, when they are due, and how to access needed services; and monitoring the quality of care provided to the beneficiary population. MCOs provide on-going outreach to the beneficiaries enrolled in the health plan, informing and encouraging them to seek needed services. In order to do this appropriately, regular reports are run by the MCOs to identify children who are due or overdue for particular preventive

[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 District had satisfied the exit criteria.
[3] Provisions relating to the fourth category were dismissed by Court order in 2013 because those requirements conflicted with the Affordable Care Act (ACA).

services or to identify beneficiaries who may need interventions based on multiple trips to the emergency room or some other unusual care pattern. As a part of their contract with the District, MCOs are also responsible for various reporting requirements so that the District can monitor the outreach services being provided by the MCOs to the beneficiaries. This includes quarterly reports on utilization of and notice and outreach for EPSDT services.

DHCF, through its own efforts and in working with 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 FY 2020 was 52%, while the District reported a utilization rate of 54% in FY 2021. In FY 2020 and FY 2021, the District was above the latest available national average for well-child visits. 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 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 52% of DC Medicaid children aged 3-20 years old received any dental service in FY21, while the national average in FY20 for the same measure was 46%.

As DHCF continues to work with the MCOs on outreach for preventive services in order to improve utilization of primary and dental care, the agency remains proud of the progress the District has made to ensure access to medical care for Medicaid-enrolled children.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

29. For Medicaid enrollees required to renew manually in FY 2022 and FY 2023, to date, please provide (preferably broken out by month):

a. The number and percentage of households that returned renewal forms prior to the end of their certification period.

b. The number and percentage of households that were terminated for failure to manually renew prior to end of their certification period.

c. The number and percentage of households that 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.

Response:

a. Due to the PHE, no individuals were required to renew manually. All individuals were extended for one year upon their annual renewal cycle throughout the duration of the PHE. Recertifications will resume when the continuous enrollment requirement ends March 31, 2023.

b. None.

c. None.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

30. For enrollees who were terminated but manually renewed during the grace period, please provide:

a. The average number of days enrollees were without coverage.
b. The number of enrollees who were without coverage for:
i. 30 days or less
ii. 31 to 60 days
iii. Longer than 60 days

Response:
None. The continuous enrollment requirement halted Medicaid recertifications beginning March 2020. Recertifications will resume when the continuous enrollment requirement ends March 31, 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

31. The number and percentage of households 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.

Response:
None. The continuous enrollment requirement halted Medicaid recertifications beginning March 2020. Recertifications will resume when the continuous enrollment requirement ends March 31, 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

32. 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.

Response:

a. Due to the PHE, no individuals were required to renew manually. All individuals were extended for one year upon their annual renewal cycle throughout the duration of the PHE.
b. There have been no issues with notices distribution to Medicaid recipients.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

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

Response:
Currently, there are approximately 41,000 District residents covered by a combination of both Medicare and Medicaid (also known as dual eligibles), including the majority of the District's long-term services and supports (LTSS) users. Dually eligible individuals must navigate both Medicaid and Medicare delivery systems and may experience greater fragmentation of care across their joint Medicare and Medicaid coverage.

Since 2018, DHCF has increased its focus and efforts on improving care for dual eligibles. Consistent with the agency's strategic objectives, long-term care reforms planned by DHCF have sought to (1) promote integration of services across the care continuum, by improving integration of Medicare and Medicaid for dual eligibles and coordinating between acute & primary care and LTSS, (2) empower health care providers and health plans to take on greater accountability for health outcomes of beneficiaries in their care, and (3) promote access to high-quality, person-centered care.

DHCF continues to make incremental changes to existing programs, but the implementation of the expanded District Dual Choice program represents one of the most significant changes to the publicly funded coverage for dual eligibles and long-term care users in some years. District Dual Choice was designed to integrate Medicare and Medicaid into a single program, including all Medicare benefits, supplemental Medicare benefits, and any applicable Medicaid services. The model seeks to promote improved outcomes through the use of a coordinated, interdisciplinary model of care, and incorporate value-based payment models into the delivery of LTSS.

The expanded program was developed on the foundation of an existing Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) program in place in the District since 2013. DHCF is required by federal rules to have a State Medicaid Agency Contract (SMAC) in place with all D-SNPs operating within the District. While the SMACs must meet specific regulatory requirements, DHCF is both permitted and encouraged to include additional elements that advance its programmatic goals for dually eligible enrollees.

Consistent with federal guidance and the agency's reform efforts to promote a health care system that provides whole person care and improves health outcomes, DHCF implemented an expansion of the D-SNP model, a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP), on February 1, 2022, to offer both Medicaid and Medicare benefits through a single health care plan. Previously, people enrolled in the program accessed their Medicaid benefits through fee-for-service Medicaid and their Medicare benefits through a health plan. After the launch of the expanded program, the health plan selected to operate the HIDE SNP (UnitedHealthcare) provides Medicaid benefits as well, combining both sets of services into a "one-stop shop."

Dual Choice simplifies Medicare and Medicaid coverage into a single entity responsible for

financing, coordinating and delivering all care. The health plan is paid a monthly lump-sum capitation payment and must cover all Medicaid services, with some exceptions – effectively blending Medicare and Medicaid payments to offer comprehensive, wraparound benefits, including coverage of preventive and medical benefits, and for those who qualify, long-term care and other services.

As of September 30, 2022, Dual Choice served approximately 12,800 enrollees from all DC wards. As of January 31, 2023, just under 14,000 individuals are enrolled in the Dual Choice Program. All dual eligibles are eligible for the voluntary program, including adults 21+ who have both Medicare and Medicaid coverage of any kind, as long as they are dually eligible at the time of application. This includes individuals who are "partial benefit duals" or "QMB-only" who do not have full Medicaid coverage, those in Medicaid Home and Community-based Services (HCBS) waivers, individuals with "community" Medicaid, and individuals in nursing facilities. More than 40 percent of Dual Choice enrollees are partial-benefit duals; approximately 13 percent are also enrolled in the EPD Waiver.

DHCF expects the Dual Choice program to continue to grow in FY23 and offer the opportunity – through this integration of benefits – to improve other features of duals' care, such as improved beneficiary satisfaction and reduced inpatient hospital admissions.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

34. How does DHCF define home health services in its managed care model? What is the staff to client ratio for home health services? What home health aide services are reimbursed under Managed Care Organization home health services?

Response:
Medicaid-covered home health services are defined in the District's Medicaid State Plan. These services include skilled services provided by licensed nurses or therapists (e.g., physical therapy), home health aide, and personal care aide services. Such services are delivered to eligible enrollees by Medicaid-enrolled home health agencies licensed to provide such services. The District's managed care plans contract with Medicaid-enrolled providers to serve their enrollees.

In Medicaid managed care, with the exception of affirmatively excluded services (described as "carve-outs"), health plans cover medically necessary Medicaid state plan benefits for their enrolled beneficiaries. None of the District's Medicaid managed care contracts stipulate an explicit staff-to-client ratio for home health services.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

35. Please describe the agency's plan for informing the public and beneficiaries about the termination of public health emergency (PHE) protections, including timeline, method of communication (e.g., print, media, social media), language access, and target populations or Wards.

- **a. How will DHCF conduct outreach and identify DC Medicaid beneficiaries with disabilities who will need redetermination notices in alternate, accessible formats or need other accommodations?**
- **b. How does DHCF plan to conduct enhanced outreach to people with disabilities and other vulnerable populations after a request for information or verifications is sent to ensure that these individuals receive the assistance that they need to complete the process?**
- **c. How does DHCF plan to monitor and track how many people with disabilities (e.g., long-term care beneficiaries, adults, and youth with behavioral health disabilities, DDA beneficiaries, etc.) lose Medicaid coverage as a result of the Medicaid eligibility redetermination and unwinding process, including tracking trends of those individuals that lose eligibility due to procedural denials?**
- **d. How will DHCF track whether requests for accommodations (e.g., assistance to complete the process, etc.) in the Medicaid redetermination and unwinding process are provided?**

Response:

The agency's plan includes communication and advertising to beneficiaries about the end of protection and impact to Medicaid coverage. The method of communication will include digital, traditional, and out-of-home (transit) advertising development and placement to include targeted populations in the District. The Advertising Plan includes digital media outreach (e.g., website updates, email outreach, social media, text message scripts and systems for DHCF to send messages to beneficiaries, etc.). The plan includes targeted advertisement through bus ads in locations in Wards 4, 5, 6, 7, and 8; TV and radio advertising around local news times (WUSA9, NBC4, etc.); agency-specific press releases; a dedicated one-stop website for all pertinent information about the end of the PHE, mailers/handouts/door hanger events, and more. The website will be translated into multiple languages.

Additionally, DHCF is developing a Communication Toolkit to assist stakeholders who interact with Medicaid beneficiaries with understanding the unwinding process and in conducting their own outreach operations. The Communications Toolkit is being developed with the help of a contracted vendor. The Toolkit is designed to assist stakeholders and DHCF staff members less familiar with eligibility functions with communication with program beneficiaries; homeless and housing unstable populations; health care providers; internal stakeholders and staff; application assisters or entities that help with applications and renewals; advisory groups; community-based organizations and Associations; and anyone else who needs to use the Toolkit.

Timeline: See chart below:

a. The District will engage with providers, facilities, managed care organizations (MCOs) and other community advocates and organizations. The District intends to have an open public and stakeholder bi-weekly townhall meetings. DHCF plans to add additional information in their notices on ways in which a beneficiary can receive additional assistance or need other accommodations.

b. As mentioned above, we will continue to work with our community partners who serve Medicaid beneficiaries and to keep them informed about the renewals/ information that are being sent to the beneficiaries they assist. The District has also increased modalities to submit information for providers who assist beneficiaries and for beneficiaries to have multiple ways to submit verifications. These modalities include mail, drop off, our online system District Direct and our online provider system Partner Portal.

c. DHCF is working to extract eligibility data from DCAS that provides additional detail on the outcomes of renewals. While DHCF currently monitors the number and characteristics of individuals who do or do not renew, existing analyses do not specifically identify those who lose coverage for procedural reasons (e.g., failure to respond) versus an affirmative determination of ineligibility. Once the additional renewal outcome data are available, DHCF will have the ability to use Medicaid claims information and other beneficiary characteristics to monitor a variety of vulnerable populations, including individuals with disabilities.

d. DHCF is unable to track requests for assistance. However, the Department of Human Services (DHS) Economic Security Administration (ESA) has established a customer service staff ambassadors' program throughout the service centers to assist District residents and beneficiaries with completing their renewals, answering questions, and providing assistance as needed.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

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

Response:
As of 1/18/2023, there were approximately 25,000 beneficiaries who might otherwise have been terminated from Medicaid if not for PHE protections. This group includes, for example, beneficiaries who self-reported a change in income or aged out of an eligibility category and do not appear eligible for another based on information currently available to DHCF.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

37. 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 has made changes to the administration of the District of Columbia Medicaid State Plan (and any waivers thereof), the DC Health Care Alliance Program (Alliance), and the Immigrant Children's Program (ICP) in response to the public health emergency (PHE). The changes include service expansions, reimbursement increases, and changes to eligibility processing for Medicaid beneficiaries.

The authorities the District utilized include emergency Medicaid state plan amendments (SPA), Section 1915(c) Waiver Appendix K, and Section 1135 Waivers.

- Emergency SPAs permit DHCF to make changes to the amount, duration, and scope of benefits covered under the District of Columbia Medicaid State Plan, as well as update provider reimbursement methodologies established therein.
- The Section 1915(c) Waiver Appendix K permits DHCF and sister agencies to make changes to the amount, duration, and scope of benefits covered under the District's 1915(c) Home and Community-Based Waiver programs, as well as update the provider reimbursement methodologies established therein.
- Section 1135 Waivers permit DHCF to request authority from CMS to waive or modify federal Medicaid requirements to mitigate the consequences of the COVID-19 pandemic.

See Attachment Q37 for a list of the COVID related SPAs
Utilization of these authorities is tied to the duration federal public health emergency and DHCF's ability to utilize them will terminate on or near the end of the federal public health emergency.

Additionally, significant changes to the Medicaid program were authorized through federal legislation. The Families First Coronavirus Response Act (FFCRA), for instance, authorized enhanced federal funding for Medicaid programs conditioned upon Maintenance of Eligibility (MOE) requirements that prohibit disenrollment in most circumstances. Further, the American Rescue Plan Act (ARPA) extended coverage of COVID-19 vaccines and treatment services to limited benefit populations at no cost to states and provided an enhanced funding opportunity for State Medicaid programs to spend on increasing access to HCBS.

Until the passage of the Consolidated Appropriations Act of 2023 (Omnibus bill), signed into law on December 29, 2022, FFCRA's continuous coverage requirements, as well as FFCRA's 6.2% temporary Federal Medical Assistance Percentage (FMAP) increase, were tied directly to the duration of the federal PHE. The Omnibus bill sets March 31, 2023, as the definitive end date to the Medicaid continuous coverage requirement; meaning the District will resume full Medicaid redeterminations beginning April 1, 2023.

On January 11, 2023, the PHE was renewed and is expected to last for a full 90 days. Other programmatic changes remain tied to the federal PHE declaration and will continue. On January 30, 2023, the Biden Administration announced the PHE will conclude on May 11, 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

38. 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 put participants in the same household together? Does it plan to?
d. Does the Department have an estimate of how many people are or will be ineligible after redetermination?

Response:

a. DHCF plans to take 14-months to complete redeterminations.
b. DHCF plans to hire additional staff resources to assist with redeterminations.
c. DHCF plans to readjust the recertification periods for beneficiaries in MAGI Medicaid households.
d. During the public health emergency, the District's Medicaid enrollment has grown by 20 percent, from approximately 254,000 beneficiaries in February 2020 to approximately 304,000 at the end of 2022. While DHCF is updating its enrollment projections to incorporate the latest available information (e.g., on timing for the end of continuous coverage), previous estimates have assumed that overall Medicaid enrollment will decrease by more than 10 percent during a 12-month "unwinding" period for eligibility redeterminations.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

39. 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 modified adjusted gross income (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?**

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

a. District Direct contains specific rules 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 programmed with specific questions to screen for disability-based categories. The system will automatically determine eligibility based on rules logic for the category in which the individual is eligible for.

c. Prior to making a determination of ineligibility for non-MAGI beneficiaries, District Direct is automatically programmed to evaluate the beneficiary for eligibility under all categories before termination. DCAS gathers needed information on the initial application or renewal, and if additional information is needed, a notice will be issued to the beneficiary.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

40. Does the Department have plans for enhanced 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? If so, describe how this analysis be undertaken.
b. Has or will the District take any action to help such individuals be re-enrolled within the 90-day reinstatement window?

Response:
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. As discussed in 35(c), DHCF is working to extract eligibility data from DCAS that provides additional detail on the outcomes of renewals. While DHCF currently monitors the number and characteristics of individuals who do or do not renew, existing analyses do not specifically identify those who lose coverage for procedural reasons (e.g., failure to respond). Once the additional renewal outcome data are available, DHCF will have the ability to use Medicaid claims information and other beneficiary characteristics to monitor a variety of vulnerable populations, including those who indicated a preferred language other than English on their applications, are medically frail, or are older adults.

b. DHCF plans to work with our Managed Care Plans, provider community, advocates, and other stakeholders 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
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

41. 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:

a. Medicaid renewals are currently automated due to a continuous coverage requirement in place since March 2020. DHCF provides enrollment information that is updated monthly and available on the DHCF website at https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports. Breakouts include but are not limited to category of eligibility.

b. DHCF has monitored the monthly number of terminations throughout the public health emergency. Permissible reasons for Medicaid termination are currently limited to non-residency in the District, death, or a request to disenroll. The DCAS eligibility system records reasons for closure and routine reviews are conducted to ensure that coverage changes are appropriately communicated to DHCF's Medicaid Management Information System, which governs the payment of health care providers and managed care plans.

c. DHCF will continue to monitor enrollment, renewal, and termination statistics and make this information available via its website and through stakeholder forums. Medical Care Advisory Committee (MCAC) meetings provide an ongoing opportunity for public engagement. In addition, DHCF is currently hosting biweekly community meetings to provide updates on its restart of Alliance and Immigrant Children's Program renewals, which can be adapted in the future to also cover Medicaid.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

42. 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
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

43. For the Health Care Alliance program, please provide enrollment and spending/costs, and utilization data, both current and projected, including statistical information by gender for FY 2022 and FY 2023, to date.

Response:

For costs associated with the Alliance program, please see the response to oversight question 18. For utilization data, please see the attachment to Q43. Enrollment information is updated monthly and available on the DHCF website at https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

44. Please describe any changes to the administration of the Alliance program during FY 2022 and FY 2023, to date.

Response:
In FY 2022, DHCF launched District Direct which expanded submission modalities, allowing Alliance applicants and beneficiaries to apply and renew coverage for medical assistance and submit verification documents online. Effective November 15, 2022, the rules to determine eligibility for Alliance changed to Modified Adjusted Gross Income (MAGI) methodology which aligned with the rules for MAGI Medicaid groups and removed the resource test requirement. Another change followed the implementation of the Fiscal Year 2022 Budget Support Act, which removed the face-to-face interview requirement. Finally, the every six month recertification requirement was eliminated and replaced with an annual requirement, effective October 2022. Alliance renewals restarted in July 2022 and continue a rolling monthly cycle.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

45. Please describe any changes to the administration of the Alliance program that the Department anticipates implementing during the remainder of FY 2023.

Response:
DHCF does not anticipate any changes to the administration of the Alliance program for the remainder of FY 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

46. Regarding Health Care Alliance Program re-certifications:

- **a. For enrollees required to recertify by October 31, 2022, change the dates but keep question, please indicate:**
  - **i. The number of enrollees who were required to recertify by October 31, 2022;**
  - **ii. The number of enrollees who:**
    - **A. Successfully completed recertification;**
    - **B. Did not successfully complete recertification;**
    - **C. Were terminated for failure to recertify by October 31, 2022;**
    - **D. Were successfully reinstated following termination for failure to recertify by October 31, 2022.**

Response:

a. Due to a continuous coverage policy in effect for Alliance and Immigrant Children's Program (ICP) beneficiaries from March 2020 through August 2022, individuals enrolled in these programs were not required to complete a renewal to maintain coverage. Beginning with those due to recertify in August 2022, Alliance and ICP enrollees have been up for renewal on a rolling basis through January 2023, with notices mailed 60 days in advance for each cohort.
   i. As of February 7, 2023, there were approximately 28,700 Alliance and ICP enrollees required to recertify by August 31, 2022 through January 31, 2023.
   ii. Numbers of enrollees as of February 7, 2023:
      A. Approximately 9,700 Alliance and ICP enrollees due for a renewal by August 31, 2022 through January 31, 2023, have been recertified. Due to ongoing processing of renewals, the number with a recertification will increase for several months into the future.
      B. Approximately 19,000 Alliance/ICP beneficiaries due for a renewal by August 31, 2022 through January 31, 2023 have not been recertified. Due to ongoing processing of renewals, the number without a recertification will decrease for several months into the future.
      C. Approximately 19,000 Alliance/ICP beneficiaries due for a renewal by August 31, 2022 through January 31, 2023 are currently terminated for failure to recertify. Due to ongoing processing of renewals, the number remaining terminated will decrease for several months into the future.
      D. Approximately three-quarters of the Alliance and ICP enrollees due for a renewal by August 31, 2022 through January 31, 2023 who recertified were successfully reinstated during a grace period following termination for failure to recertify. Grace periods for those due to renew in November 2022 through January 2023 have not yet ended. Due to ongoing processing of renewals, the number with reinstated coverage will increase for several months into the future.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

47. Starting October 2022, Alliance certification periods moved from 6 months to 12 months, and no longer require face-to-face interviews. Could you provide an update about:

a. The impact of this change on the Alliance population;
b. The benefits of this approach both to enrollees and the agency; and
c. How the agency plans to monitor the efficacy of this approach moving forward?

Response:
The DC Health Care Alliance Program (Alliance) is a locally-funded medical assistance program for District residents who are not eligible for Medicaid, Medicare, or other health insurance. The program offers health care coverage at no cost to enrollees.

On October 1, 2021, the Alliance face-to-face interview requirement at initial application and recertification was eliminated. Effective October 1, 2022, individuals enrolled in the Alliance program will be required to recertify once every twelve (12) months. Additionally, in November 2021, DHCF made it possible for District residents to apply/recertify their Alliance benefits online by utilizing District Direct, the District's integrated benefits portal. Finally, effective October 2021, the Alliance program follows the same Modified Adjusted Gross Income methodology that is used determine financial eligibility for certain Medicaid populations; meaning the Alliance program no longer has a resource test.

All these changes happened in a similar timeframe, during the COVID-19 public health emergency, so assessing the individual impact each change is challenging. As a reminder, DHCF did not restart Alliance recertifications until July 2022. The agency's experience under the new recertification requirements has been relatively short lived.

In sum, DHCF expects that the elimination of the face-to-face requirements and the 12-month certification period are welcome changes for beneficiaries, because it will decrease the effort needed to retain access to benefits.

DHCF works with DHS to ensure timely Alliance application processing. Over time, the elimination of the face-to-face interviews and the 12-month certification period should reduce DHS' workload.

DHCF does not have concrete insights to share now, but going forward DHCF can review the impact of these changes on churn in the program relative to historical trends to gauge their overall impact.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

48. Please provide us with the total number of elderly and persons with disabilities (EPD) waiver participants in FY 2022 and to date in FY 2023.

Response:
The enrollment in the elderly and persons with disabilities (EPD) Waiver is 5,473 as of January 27, 2023.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

49. Please provide us with the total number of EPD waiver participants who are currently receiving more than 16 hours of personal care aide (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?

Response:
Based on assessment data from 9,638 assessments completed during FY2022:

a. 3.0 percent of all assessment results recommended 24 hours of personal care aide (PCA) services per day, seven days per week.
b. Another 4.8 percent of assessment results recommended 17 or 18 hours of services per day, with a negligible percentage (two assessments out of the total) recommending 19 to 23 hours per day. Another 3.8 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
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

50. 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?

Response:

To date 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
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

51. Since DHCF 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 February 2023, 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 case management system 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. By early 2022, all but one of these individuals had been assessed using the interRAI. and 38 (75 percent) had at least one assessment that recommended 24 hours per day. The average recommended hours of subsequent assessments for these 51 beneficiaries were more than 20 hours per day.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

52. 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?

Response:
The 16-hour cap implemented in the 2020 EPD Waiver amendment was removed from the EPD Waiver in its 2022 renewal of the waiver program. Questions 52e and 52g are not applicable.

Over the course of the last three 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 to promote whole-person care and ameliorate over-dependence on any single Medicaid benefit. 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. These have also included provider-specific calls with both HHAs and ADHPs regarding routine operations, PHE policies and updates, assessment and care management, and other pressing topics of interest to providers.

Throughout FY22, DHCF continued to convene weekly all-HHA and all-ADHP meetings, as well as frequent one-on-one technical assistance calls and meetings with individual HHAs or ADHPs. DHCF employed these and other channels to communicate with providers about PHE flexibilities and PHE-specific challenges, including HHA staffing shortages; DHCF has presented about enhanced payment rates, staffing contract flexibilities, retainer payments, remote service delivery, and process flexibilities implemented to facilitate care delivery throughout the PHE and workforce shortages.

During the last three 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. ADHPs do not report data on their total patient capacity to DHCF. 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 three new facilities enrolling as EPD Waiver providers during the last two fiscal years. Both ADHPs and ALRs increase the opportunity for community integration for Medicaid beneficiaries in need of long-term services and supports.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

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

Response:
DHCF continues to inform and update its community-based providers and all long-term services and supports (LTSS) stakeholders 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.

DHCF has developed and is implementing a plan to sunset LTSS-related process flexibilities on a rolling basis to the extent federal requirements permit, so that beneficiaries experience any PHE-related changes in phases. For example, face-to-face assessments resumed in November 2022 in order to identify and resolve any arising operational issues transitioning back to in-person conduct of assessments. Consistent with federal guidance, DHCF will resume eligibility redeterminations and changes to service authorizations beginning April 1, 2023. DHCF has developed and distributed beneficiary-facing materials to providers and stakeholders for beneficiary engagement and will continue to do so throughout various roll-back activities.

In addition, DHCF has prepared an outreach, education and communication plan to inform and engage all Medicaid beneficiaries – including those who are elderly or who have disabilities – and communicate changes coming with regarding to Medicaid eligibility and coverage.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

54. Please report the number of the individuals authorized to receive DC Medicaid PCA services who did not receive all their approved EPD Waiver and/or State Plan PCA service hours due to personal care aide staffing shortages in FY 2022?

Response:
While DHCF receives complaints and grievances regarding staffing shortages and gaps, these data are anecdotal and noncomprehensive; DHCF has no comprehensive, reliable source for data capturing staffing-specific gaps in care. Claims or utilization data reflecting service delivery are impacted by other phenomena, such as services not delivered for other reasons (refusals, hospitalizations) or lack of documentation to support billing for services.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

55. Please specify the number of D-SNP Medicaid beneficiaries who had their PCA service hours reduced because of a provider's reassessment for these services during the fee-for-service transition period.

a. Please specify the number of D-SNP Medicaid beneficiaries who had their PCA service hours terminated.

b. Please specify the number of D-SNP Medicaid beneficiaries who had their PCA service hours reduced to the point they were no longer eligible for the EPD waiver.

Response:

During the transition or "continuity of care" period in Dual Choice implementation, the health plan neither reduced nor terminated LTSS benefits based on a provider's reassessment of the beneficiary's need for such services. Consistent with the agency's operations during the public health emergency, the Dual Choice health plan continued to stay such adverse actions as recommended by a reassessment of medical necessity until DHCF resumes eligibility redeterminations and service reductions after April 1, 2023, consistent with CMS guidance.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

56. The Fiscal Year 2023 Budget Support Act of 2022 included the Direct Support Professional Payment Rate Amendment Act of 2022. Provide an update on the implementation of this subtitle, including:

a. Work toward implementation in FY2022 and FY2023 to date;
b. An update on the State Plan Amendment or waiver process;
c. Increases provided in FY2022 and FY2023, to date, for direct care professionals, including dollar amounts;
d. Goals and milestones related to the FY2025 implementation of the adjusted reimbursement rate for direct care service providers; and
e. A copy of any required reports to the Council completed thus far

Response:

a. DHCF worked collaboratively with Associations and providers to provide and overview and received feedback on the Districts intent to implement the Act as written. DHCF is utilizing HCBS ARPA funds to support the efforts of this project to support cost through March, 2025.To date, DHCF has completed the following

- **Payment Method:** DHCF will establish a supplemental payment to providers in FY23 and FY24 and implement the rates effective January 1, 2025. The purpose of the supplemental payment is that it will establish parity across Providers so that when the industry wide rates are set, it will not have a negative impact on providers because the wages will be aligned.
- **Requirements of the District:** DHCF will include in the payment the increased amount for salary and wage, fringe benefits and administrative cost (based on the approved Industry specific rate methodology) and a five (5) percent vacancy factor. Payments will be processed no later than the end of February. Funding will support a full 12 month period (Calendar year 2023)
- **Requirements of Providers:** Once funding is received providers must determine how they will achieve the increase in DSP wages to meet an average of 110% of the current LW. Providers are required to pay the funds retroactively to January 1, 2023.
- **Reporting Requirements:** Provider were asked to submit a schedule in November which provided information specific to pay rolled DSP's. A template and overview were provided. This helped establish the amount of the supplemental payment for each provider. The second report is due July 31, 2023 to update the file showing salaries as of January 1, 2023 through June 30, 2023. DHCF will utilize this information to determine if the amount provided sufficient to absorb the July wage increase through the end of the calendar year. The annual report is due January 30, 2024.

- **Allotment Amount:** DHCF will pay 110% of the Living Wage in FY23 to support enhanced DSP wages for January 1, 2023 through December 31, 2023. This supplemental payment is originally based on the current living wage of $16.50; resulting in an average of $18.50. In FY24, DHCF will increase the supplemental payment to cover the additional 107.6%, resulting in 117.6% in FY24 (a year early).

b. The People with Intellectual and Developmental Disabilities and the Individual and Family Supports Waivers were amended and approved with an effective date of October 1, 2022. The Elderly and Physically Disabled Waiver was approved with an effective date of January 1, 2023. The State Plan Amendment has been drafted. Recently, DHCF met with CMS on reporting requirements and the amendment is being submitted to CMS shortly. DHCF provided Notice for all three sources so that once approved, the State Plan Amendment will also be effective January 1, 2023.

c. To date, DHCF has received 114 DSP reports from providers across eligible home and community-based providers. We continue to do outreach at meetings, work with our Associations and send emails. DHCF will begin issuing notices and payments in February to ensure that all providers that have submitted reports will have a payment processed by the end of February.

d. Please see Response A

e. The report to Council has not been submitted as of today and will be completed once we have made the payments to provide more useful information and statistics.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

57. Provide an update on the work of the DHCF Maternal Health Advisory Group. Please include:

a. Group membership;
b. Project focus and recommendations made in FY 2022 and FY 2023, to date;
c. Progress toward implementation of recommendations in FY 2022 and FY 2023, to date.

Response:
Please refer to the attachment for the Maternal Health Advisory Group membership.

The focus of the Maternal Health Advisory Group has been on providing stakeholder input to develop and implement the following:

- The State Plan Amendment (SPA) from DHCF on the extension of Medicaid coverage from sixty day to twelve months postpartum.
- The State Plan Amendment to authorize doula services.
- The legislative provision that MCOs cover non-emergency transportation for Alliance and Immigrant Children's Program members.

While the group did not issue formal recommendations as a body, input from group members and discussion at meetings shaped the Doula Services State Plan Amendment and related guidance in several ways. For example, the District's decision to reimburse differently for perinatal and postpartum doula visits came from input from the Maternal Health Advisory Group. In addition, input from the Maternal Health Advisory Group helped determine the total number of doula visits that DHCF would reimburse.

DHCF drafted, submitted, and received CMS approval for the two SPAs and has implemented the provision for non-emergency transportation. The Maternal Health Advisory Group no longer serves as an active official body since the primary objectives have been completed. DHCF does send occasional communications to the group for assistance in conducting outreach for participating in doula enrollment training and other DHCF requirements pertaining to doula training.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

58. Provide the membership of the Perinatal Mental Health Task Force, and the expected timeline of the Task Force's activities.

Response
Please refer to the attachment for the Perinatal Mental Health Task Force membership.

On September 26, 2022, DHCF sent out a Medicaid Director Letter that served as an announcement for the stakeholder engagement and agency action on perinatal mental health, settings the scope, structure, and application process for the DHCF Perinatal Mental Health Taskforce and directing stakeholders on ways to contact and submit comments to the agency on ways to improve services and coverage related to perinatal mental health in advance of upcoming meetings.

On Wednesday, October 12, 2022, DHCF held an interest meeting for the task force applicants. Applications were due October 21st. Agency staff made selections and sent them to the Director for approval. Selected candidates had until January 6th to accept whether they would participate in the Task Force.

The first meeting was held virtually on January 31st at 4 pm. The Task Force will continue to meet monthly until September 2023, when it will finalize recommendations for submission to Council and the Mayor. Subcommittees will be formed after the election of the non-government co-chair and will meet starting in March. We anticipate having draft recommendations in July.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

59. Provide an update on the implementation of the State Plan Amendment (SPA) to cover doula services. Include:

a. When the SPA took effect.
b. The number of doulas currently receiving reimbursement.
c. The expected number of doulas to receive reimbursements in FY 2023.
d. Total reimbursements distributed to Doulas in FY 2022 and FY2023, to date.
e. A narrative explanation on how DHCF continues to make doulas aware of their eligibility for reimbursement.

Response:

a. The State Plan Amendment to cover doula services is effective as of October 1, 2022.
b. Two (2) doulas have billed claims for reimbursement for services rendered.
c. While we cannot say for certain, we know that seven (7) doulas have started registration, two (2) have enrolled, and we expect both numbers to grow and doulas to start billing DHCF. We expect knowledge of and interest in the program to increase with the start of the creation of doula certification through DC Health and after Certification and training standards are established by DC Health.
d. No doula reimbursement was given in FY22 because the program was not yet established. In FY23, no doula reimbursement has been given out so far.
e. DHCF arranged eight (8) trainings on doula enrollment in October 2022, and provided notice through the Maternal Health Advisory Group listserv as well as other traditional means of communication (MCAC meetings, provider transmittals). DHCF continues to communicate through the listserv about enrollment opportunities.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

60. Provide the number of midwives who are eligible for Medicaid reimbursement.
a. Provide the number of midwives currently receiving Medicaid reimbursement.

Response:
As of January 26, 2023, there are 87 midwives enrolled in the DC Medicaid program. A subset (38) of the total enrolled midwives have billed Medicaid for reimbursement in FY 2022.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

61. Provide an organizational chart for the Office of the Health Care Ombudsman and Bill of Rights.

Response:
Please see the attachment for the organizational chart for the Office of the Health Care Ombudsman and Bill of Rights.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

62. Provide when the Ombudsman was appointed, how they were selected, and how they meet the criteria provided in D.C. Code § 7-2071.02(c), including any additional criteria required by the Department.

Response:
The Office of Health Care Ombudsman and Bill of Rights was established in 2009 to counsel and provide assistance to uninsured District of Columbia residents and individuals insured by health benefits plans in the District of Columbia regarding matters pertaining to their health care coverage. The position for the Ombudsman is not an appointed position. Recruitment for the Ombudsman follows the DC government recruiting process. Position requirements, skills, and major duties are specified in the position description.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

63. Provide a copy of the most recent independent evaluation of the Ombudsman Program as required by D.C. Code §7-2071.03. Additionally, under this same code citation, provide narrative text regarding how the department decided whether to renew contracts based on the evaluation, and which contracts were considered.

Response:
Please see attachment to Q63 for a copy of the independent evaluation of the Ombudsman Program. The evaluation was completed by an academic institution, the University of the District of Columbia.

The Ombudsman Program does not currently operate its program utilizing any significant contracts or vendors. The evaluation didn't review any contracts, so their renewal or termination was not considered.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

64. Provide a copy of the most recent annual report required to be submitted to the Council, Mayor, Department of Health, and Department of Insurance Securities and Banking in accordance with D.C. Code §7-2071.06.

Response:
The report is pending final approval by the Executive Office the Mayor. A copy of the official FY 2021 Annual Report will be transmitted to Committee upon finalization.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

65. Provide narrative text about outreach efforts the Department undertook to promote the work of the Office of the Health Care Ombudsman and Bill of Rights and encourage the public to utilize its services.

Response:
The Office of the Health Care Ombudsman and Bill of Right's office (OHCOBR) has an Education and Outreach subcommittee under the Advisory Board that consists of stakeholders. The Advisory Board is chaired by a member of the community and co-chaired by a staff person within the Ombudsman's office. The OHCOBR participates with the Mayor's and Council ward activities, the Department of Aging and Community Living, District of Columbia Public and Chartered Schools, Department of Human Resource's Open Enrollment events for District Government employees, and various other health fairs throughout all eight wards. We also advertise the OHCOBR's program on NBC4 and Telemundo.

Health Care on Tap was created by the OHCOBR and it is an outreach event that takes place with a smaller group. These events often take place within churches that have requested that OHCOBR come and speak with their congregations, in senior buildings where management has requested our presence to speak to its residents, and with the District of Columbia's Office of Veterans Affairs to name a few. These smaller outreach events allow for a more personal and one-on-one experience.

DEPARTMENT OF HEALTH CARE FINANCE
FY22-23 PERFORMANCE OVERSIGHT QUESTIONS

66. Outline any challenges to the success of the Office that may require policy or budgetary adjustments.

Response:
Currently, there are no challenges to the success of the Office that may require policy or budgetary adjustments.

Utilization Data

	FFS Medicaid			MCO Medicaid	
Provider type description	**Total paid claims**	**Total unique beneficiaries with at least one claim**		**Total paid claims**	**Total unique beneficiaries with at least one claim**
Adult Day Health 1915(i)	7,987	346		798	121
Ambulance, Air Transport	8	8		3	3
Ambulance, Private	2,537	1,718		175,586	10,312
Ambulance, Public	39,286	21,489		3,785	2,096
Ambulatory Surgical Centers	202	151		1,604	1,332
Audiologist	71	66		17,954	3,693
Behavioral Hlth Stabilization	1,393	116		0	0
Birthing Centers	1	1		2	2
Clinic, Adlt Alc/Subst Abuse	178,538	2,871		3,741	1,010
Clinic, Dental	7	7		233	152
Clinic, Family Planning	17	16		2,536	1,330
Clinic, Fed Qualified Health	23,383	7,546		315,455	77,425
Clinic, Mental Health	21,963	4,589		46,237	5,441
Clinic, Private	1,696	566		14,962	6,227
Clinic, Youth Alc/Subst Abuse	11	11		2,098	539
Crossover Claims Only 1500	553	176		2,231	468
Day Treatment	0	0		2,697	21
Dentist	7,363	3,818		67,292	33,276
Dentist, Group Practice	9,597	4,902		92,927	48,475
Dentist, Waiver	1,176	556		308	206
Doctor Of Osteopathy	1	1		417	267
Durable Medical Equipment	68,991	8,642		93,488	19,587
Early Intervention	171	40		0	0
EPD Waiver	153,452	5,373		17,125	1,555
FQHC per member per month	178,706	12,798		0	0
General Non-Billing	0	0		16,135	3,322
Hearing Aid Dealer	82	74		530	303
Hemodialysis, Freestanding	9,994	497		6,529	611
Home Health Agency	247,088	4,437		145,523	3,250
Hospice	278	82		587	230
Hospital, Emergency Access	0	0		765	412
Hospital, General	102,009	27,144		413,345	117,146
Hospital, LTAC	489	179		126	85
Hospital, Psychiatric Private	1,000	632		2,095	1,419
Hospital, Psychiatric Public	82	10		0	0
Housing Supportive Services	1,254	999		1	1
ICF/IDD	13,024	260		2,013	7

IDD Waiver	185,010	1,810		13,491	1,105
Ind Xray And Lab	613	451		2,087	1,554
Independent Lab	30,052	9,254		275,206	82,435
Independent Social Worker	1,887	189		2,875	206
Independent Social Worker Grp	946	45		9,813	754
Independent X-Ray	245	108		268	191
Marriage/Family Therapist	5	1		133	36
Marriage/Family Therapist Grp	17	2		202	18
MCO, Special Needs	0	0		22	5
Medical Transportation Broker	0	0		259,170	4,270
Mental Health Rehab Services	2,224,819	33,406		45,285	10,037
Nurse Midwives	15	9		331	183
Nurse Practitioner	30,957	2,306		16,724	4,966
Nursing Facility	46,785	3,660		3,073	896
Office State Superinten of Ed	15,499	1,593		0	0
Optician/Optical Dispensary	734	576		8,037	6,707
Optometrist	3,558	2,389		8,612	6,953
Optometrist Group	109	98		2,674	2,210
Participant Directed	359,193	1,568		85,557	502
PCA Aide	0	0		3	2
Pharmacy, Institutional	1,412	54		650	34
Pharmacy, Retail	322,086	21,621		2,488,602	159,613
Physician Assistant	0	0		115	71
Physician MD	28,083	5,902		140,389	34,701
Physician, Group Practice	287,153	31,097		889,709	139,263
Podiatrist	6,177	2,543		6,373	2,732
Podiatry Group	1,467	649		106	63
Professional Counselor	54	15		6,218	414
Professional Counselor Group	714	77		21,563	1,392
Psychologist	8	3		320	49
Psychologist Group	477	37		16,089	744
Radiation Therapy Center	0	0		1	1
Rehabiliataion Center	676	260		12,958	1,533
Residential Treatment Center	182	14		107	14
Schools, DC Public	50,923	4,021		0	0
Schools, DC Public Charter	7,681	1,073		0	0
TOTAL UNIQUE	**4,679,947**	**100,029**		**5,765,891**	**224,439**

Alliance		ICP	
Total paid claims	**Total unique beneficiaries with at least one claim**	**Total paid claims**	**Total unique beneficiaries with at least one claim**
0	0	0	0
0	0	0	0
4,225	167	112	20
1,019	679	0	0
143	109	21	18
2,285	621	122	38
0	0	0	0
0	0	0	0
0	0	28	8
24	13	3	2
50	33	11	8
61,280	13,441	10,329	2,666
3	2	323	46
280	188	24	18
0	0	58	20
76	29	0	0
0	0	0	0
6,996	3,476	532	351
4,678	2,538	1,127	617
6	5	0	0
78	49	3	3
3,999	1,767	418	143
0	0	0	0
45	4	0	0
0	0	0	0
135	109	60	41
1	1	0	0
1,884	133	0	0
394	89	51	4
33	16	1	1
0	0	7	3
32,064	9,264	3,563	1,255
6	5	0	0
0	0	3	2
0	0	0	0
0	0	0	0
0	0	0	0

97	20	10	3	
108	80	1	1	
26,264	9,255	3,159	1,420	
0	0	0	0	
0	0	39	9	
5	5	0	0	
0	0	0	0	
0	0	0	0	
0	0	0	0	
0	0	0	0	
1,063	703	325	120	
117	69	15	7	
911	369	27	24	
28	16	0	0	
0	0	0	0	
6	6	96	82	
35	32	163	153	
0	0	54	49	
0	0	0	0	
0	0	0	0	
0	0	0	0	
233,530	15,247	8,185	1,749	
4	4	0	0	
6,573	2,338	808	256	
62,111	10,194	5,156	1,381	
88	40	4	3	
0	0	0	0	
0	0	0	0	
0	0	2	1	
0	0	0	0	
0	0	1,925	59	
0	0	0	0	
501	69	9	3	
0	0	0	0	
0	0	0	0	
0	0	0	0	
451,145	**20,101**	**36,774**	**3,878**	