

2. Please provide a list of all FTE positions detailed **to** DHCF, broken down by program and activity for FY 2025 and FY 2026, to date. Include a narrative on specific role the detailed staff took at DHCF during their detail. In addition, please provide which agency the detailee originated from and how long they were detailed to DHCF.
 - a. Please provide a list of all FTE positions detailed **from** DHCF to another agency in FY 2025 and in FY 2026, to date. In addition, please provide which agency the employee was detailed to, what work they took on, and for how long.

Response:

Details to DHCF: None. There were no FTE positions detailed to DHCF for FY 2025 and FY 2026 to date.

Details from DHCF: Larissa Etwaroo, Special Projects Officer, was detailed to the Department of General Services, as a Project Manager effective August 10, 2025. Ms. Etwaroo is responsible for managing construction projects within the DC Health and Human Services portfolio. Ms. Etwaroo is slated to remain in this detail until March 31, 2026.

5. Please provide the names of the primary and alternative sexual harassment officers.
- a. List and describe any allegations of sexual harassment or misconduct committed by or against its employees received by the agency in FY 2025 and FY 2026, to date, and whether those allegations were resolved.
 - b. Has DHCF received any requests from staff in an otherwise prohibited dating, romantic, or sexual relationship for a waiver of provisions of the Sexual Harassment Order?
 - i. What was the resolution of each request?
 - ii. If a request was granted, are there limitations on the scope of the waiver?

Response:

DHCF's primary SHO is Felicia Rothchild, Human Resources Officer. The alternative SHO is Portia Shorter, Deputy Chief Operating Officer.

- a. There was one claim of sexual harassment for FY 2025. A sexual harassment claim was reported on October 15, 2024. DHCF conducted an investigation. The allegations were unsubstantiated, and the agency considers the matter resolved. There have not been any allegations to date in FY 2026.
- b. No, DCHF has not received any waiver requests regarding this matter.
 - i. Not applicable
 - iii. Not applicable

- 6. Please provide a list of employees who received bonuses, special pay, additional compensation, or hiring incentives in FY2025 and FY 2026, to date, including the amount and reason.**

Response:

There are no employees who received bonuses, special pay, additional compensation, or hiring incentives in FY 2025 and FY 2026.

7. How many performance evaluations did the agency complete in FY 2025?

- a. **How many performance improvement plans were issued in FY 2025?**
- b. **How many employees have submitted SMART Goals or other relevant workplans in FY 2026?**
- c. **For each question, provide the total number and the percentage of total employees.**

Response:

The responses below refer to performance period October 1, 2024, through September 30, 2025. DHCF completed 250 (92.25%) performance evaluations in FY 2025.

- a. DHCF did not issue any performance improvement plans for FY 2025.
- b. As practice, employee SMART Goals (Individual Performance Plans) are submitted by the immediate supervisor. DHCF submitted 260 (93.53%) Individual Performance Plans in FY 2026.
- c. See responses above.

7. How many performance evaluations did the agency complete in FY 2025?

- a. **How many performance improvement plans were issued in FY 2025?**
- b. **How many employees have submitted SMART Goals or other relevant workplans in FY 2026?**
- c. **For each question, provide the total number and the percentage of total employees.**

Response:

The responses below refer to performance period October 1, 2024, through September 30, 2025. DHCF completed 250 (92.25%) performance evaluations in FY 2025.

- a. DHCF did not issue any performance improvement plans for FY 2025.
- b. As practice, employee SMART Goals (Individual Performance Plans) are submitted by the immediate supervisor. DHCF submitted 260 (93.53%) Individual Performance Plans in FY 2026.
- c. See responses above.

Department of Health Care Finance (HT0)
FY25 Performance Oversight Hearing
Q9a- FY25 Agency Level

FY 2025

Appropriated Fund Description	Account Group (Parent Level 1)	Account Group (Parent Level 1) Description	Sum of Total Budget	Sum of Expenditure	Sum of Available Budget	Explanation
DEDICATED TAXES	701100C	CONTINUING FULL TIME	\$556,076.81	\$509,412.93	\$46,663.88	
	701200C	CONTINUING FULL TIME - OTHERS	\$74,063.55	\$74,266.97	-\$203.42	
	701300C	ADDITIONAL GROSS PAY	\$0.00	\$1,598.29	-\$1,598.29	
	701400C	FRINGE BENEFITS - CURR PERSONNEL	\$63,793.79	\$125,866.49	-\$62,072.70	
	701500C	OVERTIME PAY	\$0.00	\$551.58	-\$551.58	
	711100C	SUPPLIES & MATERIALS	\$2,090.00	\$0.00	\$2,090.00	
	713100C	OTHER SERVICES & CHARGES	\$1,254.09	-\$20,096.67	\$21,350.76	
	713200C	CONTRACTUAL SERVICES - OTHER	\$319,678.30	\$282,611.78	\$37,066.52	
	714100C	GOVERNMENT SUBSIDIES & GRANTS	\$237,591,707.04	\$234,362,409.04	\$3,229,298.00	
	717100C	PURCHASES EQUIPMENT & MACHINERY	\$2,479.46	\$0.00	\$2,479.46	
DEDICATED TAXES Total			\$238,611,143.04	\$235,336,620.41	\$3,274,522.63	
FEDERAL GRANT FUND - FPR	701100C	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00	
	701200C	CONTINUING FULL TIME - OTHERS	\$436,170.24	\$435,528.04	\$642.20	
	701400C	FRINGE BENEFITS - CURR PERSONNEL	\$80,399.61	\$80,683.75	-\$284.14	
	713100C	OTHER SERVICES & CHARGES	\$1,785.00	\$2,143.06	-\$358.06	
	713200C	CONTRACTUAL SERVICES - OTHER	\$98,560.00	\$98,560.00	\$0.00	
	714100C	GOVERNMENT SUBSIDIES & GRANTS	\$2,214,445.59	\$2,214,445.60	-\$0.01	
	717100C	PURCHASES EQUIPMENT & MACHINERY	\$327,280.80	\$327,280.80	\$0.00	
FEDERAL GRANT FUND - FPR Total			\$3,158,641.24	\$3,158,641.25	-\$0.01	
FEDERAL MEDICAID PAYMENTS	701100C	CONTINUING FULL TIME	\$18,648,789.90	\$17,730,781.55	\$918,008.35	
	701200C	CONTINUING FULL TIME - OTHERS	\$933,341.24	\$959,406.85	-\$26,065.61	
	701300C	ADDITIONAL GROSS PAY	\$0.00	\$48,354.59	-\$48,354.59	
	701400C	FRINGE BENEFITS - CURR PERSONNEL	\$4,303,933.57	\$4,258,322.79	\$45,610.78	
	701500C	OVERTIME PAY	\$0.00	\$30,532.76	-\$30,532.76	
	711100C	SUPPLIES & MATERIALS	\$39,919.16	\$30,667.45	\$9,251.71	
	712100C	ENERGY COMM & BLDG RENTALS	\$1,217,503.81	\$1,008,572.36	\$208,931.45	
	713100C	OTHER SERVICES & CHARGES	\$1,723,401.49	\$1,499,756.58	\$223,644.91	
	713101C	SECURITY SERVICES	\$55,187.72	\$51,778.68	\$3,409.04	
	713200C	CONTRACTUAL SERVICES - OTHER	\$91,718,104.01	\$83,190,653.36	\$8,527,450.65	
	714100C	GOVERNMENT SUBSIDIES & GRANTS	\$3,014,994,318.76	\$3,002,623,986.48	\$12,370,332.28	
	715200C	P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$0.00	\$0.00	
	717100C	PURCHASES EQUIPMENT & MACHINERY	\$6,480,543.84	\$6,043,231.80	\$437,312.04	
FEDERAL MEDICAID PAYMENTS Total			\$3,140,115,043.50	\$3,117,476,045.25	\$22,638,998.25	
LOCAL FUND	701100C	CONTINUING FULL TIME	\$18,129,510.42	\$16,003,267.58	\$2,126,242.84	
	701200C	CONTINUING FULL TIME - OTHERS	\$722,174.83	\$706,713.25	\$15,461.58	Vacancy savings driven by hiring freeze and internal promotions.
	701300C	ADDITIONAL GROSS PAY	\$0.00	\$44,824.74	-\$44,824.74	
	701400C	FRINGE BENEFITS - CURR PERSONNEL	\$3,468,574.82	\$4,127,101.98	-\$658,527.16	
	701500C	OVERTIME PAY	\$0.00	\$36,344.80	-\$36,344.80	
	711100C	SUPPLIES & MATERIALS	\$28,303.71	\$25,588.27	\$2,715.44	DHCF curtailed spending to close deficit in provider payments & in response to city-wide spending freeze.
	712100C	ENERGY COMM & BLDG RENTALS	\$1,360,336.14	\$1,355,437.88	\$4,898.26	Centrally managed by DGS.
	713100C	OTHER SERVICES & CHARGES	\$1,790,680.13	\$1,524,599.57	\$266,080.56	DHCF curtailed spending to close deficit in provider payments & in response to city-wide spending freeze.
	713101C	SECURITY SERVICES	\$67,451.66	\$27,594.50	\$39,857.16	Centrally managed by DGS.

	713200C	CONTRACTUAL SERVICES - OTHER	\$69,959,957.72	\$61,473,348.75	\$8,486,608.97	DHCF curtailed spending to close deficit in provider payments & in response to city-wide spending freeze.
	714100C	GOVERNMENT SUBSIDIES & GRANTS	\$952,782,000.32	\$960,050,478.57	-\$7,268,478.25	Provider payments. DHCF projected deficit throughout FY 2025 due largely to Alliance overspending.
	715200C	P-CARD CLEARING ACCOUNT BUDGET TRACKI	\$0.00	\$0.00	\$0.00	
	717100C	PURCHASES EQUIPMENT & MACHINERY	\$6,539,118.23	\$6,430,648.83	\$108,469.40	DHCF curtailed spending to close deficit in provider payments & in response to city-wide spending freeze.
LOCAL FUND Total			\$1,054,848,107.98	\$1,051,805,948.72	\$3,042,159.26	
SPECIAL PURPOSE REVENUE FUNDS	701100C	CONTINUING FULL TIME	\$1,444,817.78	\$1,228,893.53	\$215,924.25	
	701200C	CONTINUING FULL TIME - OTHERS	\$55,745.25	\$103,357.80	-\$47,612.55	
	701300C	ADDITIONAL GROSS PAY	\$0.00	\$1,871.68	-\$1,871.68	
	701400C	FRINGE BENEFITS - CURR PERSONNEL	\$26,510.22	\$301,882.23	-\$275,372.01	
	711100C	SUPPLIES & MATERIALS	\$1,747.60	\$1,747.60	\$0.00	
	713100C	OTHER SERVICES & CHARGES	\$5,371.85	-\$4,416.97	\$9,788.82	
	713200C	CONTRACTUAL SERVICES - OTHER	\$809,546.48	\$710,395.98	\$99,150.50	
	714100C	GOVERNMENT SUBSIDIES & GRANTS	\$1,102,749.00	\$1,102,749.00	\$0.00	
	715200C	P-CARD CLEARING ACCOUNT BUDGET TRACKI	\$0.00	\$0.00	\$0.00	
SPECIAL PURPOSE REVENUE FUNDS Total			\$3,446,488.18	\$3,446,480.85	\$7.33	
Grand Total			\$4,440,179,423.94	\$4,411,223,736.48	\$28,955,687.46	

Department of Health Care Finance (HT0)
FY25 Performance Oversight Hearing
Q9b- FY25 Program Level

FY 2025

Program (Parent Level 2) Description	Appropriated Fund Description	Account Group (Parent Level 1) Description	Sum of Total Budget	Sum of Expenditure	Sum of Available Budget	
AGENCY FINANCIAL OPERATIONS	DEDICATED TAXES	CONTINUING FULL TIME	\$36,984.96	\$27,828.68	\$9,156.28	
		CONTRACTUAL SERVICES - OTHER	\$209,678.30	\$184,281.50	\$25,396.80	
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$9,156.28	-\$9,156.28	
	DEDICATED TAXES Total		\$246,663.26	\$221,266.46	\$25,396.80	
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$975,906.75	\$980,159.85	-\$4,253.10	
		CONTRACTUAL SERVICES - OTHER	\$201,378.10	\$1,555,203.00	-\$1,353,824.90	
		FRINGE BENEFITS - CURR PERSONNEL	\$216,651.31	\$216,416.98	\$234.33	
		GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00	
		OTHER SERVICES & CHARGES	\$182,211.87	\$87,463.01	\$94,748.86	
		P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$0.00	\$0.00	
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00	
		SUPPLIES & MATERIALS	\$59.54	\$59.54	\$0.00	
		FEDERAL MEDICAID PAYMENTS Total		\$1,576,207.57	\$2,839,302.38	-\$1,263,094.81
	LOCAL FUND	CONTINUING FULL TIME	\$1,135,766.91	\$1,048,802.97	\$86,963.94	
		CONTRACTUAL SERVICES - OTHER	\$2,354,006.97	\$1,645,104.65	\$708,902.32	
		FRINGE BENEFITS - CURR PERSONNEL	\$252,140.26	\$257,500.42	-\$5,360.16	
OTHER SERVICES & CHARGES		\$222,703.39	\$92,214.76	\$130,488.63		
P-CARD CLEARING ACCOUNT BUDGET TRACKING		\$0.00	\$0.00	\$0.00		
PURCHASES EQUIPMENT & MACHINERY		\$0.00	-\$91.68	\$91.68		
SUPPLIES & MATERIALS		\$72.78	\$72.78	\$0.00		
LOCAL FUND Total		\$3,964,690.31	\$3,043,603.90	\$921,086.41		
SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$7.29	\$7.29		
	P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$0.00	\$0.00		
	SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$7.29	\$7.29	
AGENCY FINANCIAL OPERATIONS Total			\$5,787,561.14	\$6,104,165.45	-\$316,604.31	
AGENCY MANAGEMENT PROGRAM	DEDICATED TAXES	CONTINUING FULL TIME	\$184,277.18	\$160,100.41	\$24,176.77	
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$1,289.62	\$1,289.62	
		FRINGE BENEFITS - CURR PERSONNEL	\$25,995.05	\$30,343.99	-\$4,348.94	
		OVERTIME PAY	\$0.00	\$0.00	\$0.00	
		DEDICATED TAXES Total		\$210,272.23	\$189,154.78	\$21,117.45
	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00	
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00	
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00	
		FEDERAL GRANT FUND - FPR Total		\$0.00	\$0.00	\$0.00
	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$27,043.57	-\$27,043.57	
		CONTINUING FULL TIME	\$8,699,078.55	\$8,254,800.68	\$444,277.87	
		CONTINUING FULL TIME - OTHERS	\$535,191.12	\$548,509.98	-\$13,318.86	
		CONTRACTUAL SERVICES - OTHER	\$8,873,358.18	\$6,155,080.91	\$2,718,277.27	
		ENERGY COMM & BLDG RENTALS	\$575,126.86	\$369,300.83	\$205,826.03	
		FRINGE BENEFITS - CURR PERSONNEL	\$2,038,900.73	\$1,961,918.72	\$76,982.01	
		OTHER SERVICES & CHARGES	\$321,399.30	\$244,207.08	\$77,192.22	
		OVERTIME PAY	\$0.00	\$516.74	-\$516.74	
		PURCHASES EQUIPMENT & MACHINERY	\$279,037.80	\$258,887.55	\$20,150.25	
		SECURITY SERVICES	\$55,187.72	\$51,778.68	\$3,409.04	
		SUPPLIES & MATERIALS	\$22,564.21	\$21,147.01	\$1,417.20	
		FEDERAL MEDICAID PAYMENTS Total		\$21,399,844.47	\$17,893,191.75	\$3,506,652.72
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$25,295.19	-\$25,295.19	
		CONTINUING FULL TIME	\$7,940,482.50	\$6,984,287.34	\$956,195.16	
		CONTINUING FULL TIME - OTHERS	\$495,267.70	\$500,413.34	-\$5,145.64	
		CONTRACTUAL SERVICES - OTHER	\$6,598,431.32	\$4,826,554.20	\$1,771,877.12	
		ENERGY COMM & BLDG RENTALS	\$702,932.83	\$654,979.84	\$47,952.99	
		FRINGE BENEFITS - CURR PERSONNEL	\$1,567,536.91	\$1,849,979.27	-\$282,442.36	
		GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$97,208.79	-\$97,208.79	
		OTHER SERVICES & CHARGES	\$392,404.04	\$325,648.57	\$66,755.47	
		OVERTIME PAY	\$0.00	\$631.58	-\$631.58	
		P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	-\$4,995.00	\$4,995.00	
		PURCHASES EQUIPMENT & MACHINERY	\$341,642.77	\$364,924.36	-\$23,281.59	
		SECURITY SERVICES	\$67,451.66	\$27,594.50	\$39,857.16	
		SUPPLIES & MATERIALS	\$25,005.87	\$22,719.69	\$2,286.18	
		LOCAL FUND Total		\$18,131,155.60	\$15,675,241.67	\$2,455,913.93
		SPECIAL PURPOSE REVENUE FUNDS	ADDITIONAL GROSS PAY	\$0.00	\$1,633.06	-\$1,633.06
	CONTINUING FULL TIME		\$1,190,887.49	\$1,009,744.60	\$181,142.89	
	CONTINUING FULL TIME - OTHERS		\$55,745.25	\$103,357.80	-\$47,612.55	
	CONTRACTUAL SERVICES - OTHER		\$337,335.11	\$347,309.19	-\$9,974.08	
	FRINGE BENEFITS - CURR PERSONNEL		\$4,381.27	\$249,697.55	-\$245,316.28	
	OTHER SERVICES & CHARGES		\$5,371.85	-\$4,416.97	\$9,788.82	
	SUPPLIES & MATERIALS		\$1,747.60	\$1,747.60	\$0.00	
	SPECIAL PURPOSE REVENUE FUNDS Total		\$1,595,468.57	\$1,709,072.83	-\$113,604.26	
AGENCY MANAGEMENT PROGRAM Total			\$41,336,740.87	\$35,466,661.03	\$5,870,079.84	
DC ACCESS SYSTEM	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$467.21	-\$467.21	
		CONTINUING FULL TIME	\$1,856,963.91	\$1,628,887.59	\$228,076.32	
		CONTINUING FULL TIME - OTHERS	\$0.00	\$31,857.50	-\$31,857.50	
		CONTRACTUAL SERVICES - OTHER	\$25,708,311.41	\$23,856,881.12	\$1,851,430.29	
		ENERGY COMM & BLDG RENTALS	\$642,376.95	\$639,271.53	\$3,105.42	
		FRINGE BENEFITS - CURR PERSONNEL	\$406,845.98	\$407,176.05	-\$330.07	
		OTHER SERVICES & CHARGES	\$1,128,129.98	\$1,125,193.01	\$2,936.97	
		OVERTIME PAY	\$0.00	\$0.00	\$0.00	
		PURCHASES EQUIPMENT & MACHINERY	\$6,186,914.20	\$5,743,330.92	\$443,583.28	
		SUPPLIES & MATERIALS	\$1,146.72	\$1,146.72	\$0.00	
		FEDERAL MEDICAID PAYMENTS Total		\$35,930,689.15	\$33,434,211.65	\$2,496,477.50
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$446.12	-\$446.12	
		CONTINUING FULL TIME	\$1,900,401.57	\$1,561,512.42	\$338,889.15	
		CONTINUING FULL TIME - OTHERS	\$0.00	\$30,648.96	-\$30,648.96	
		CONTRACTUAL SERVICES - OTHER	\$27,492,679.39	\$25,679,013.69	\$1,813,665.70	
		ENERGY COMM & BLDG RENTALS	\$657,403.31	\$700,458.04	-\$43,054.73	
		FRINGE BENEFITS - CURR PERSONNEL	\$415,289.16	\$393,382.47	\$21,906.69	
		OTHER SERVICES & CHARGES	\$1,154,343.61	\$1,075,689.50	\$78,654.11	
		OVERTIME PAY	\$0.00	\$0.01	-\$0.01	
		PURCHASES EQUIPMENT & MACHINERY	\$6,184,600.29	\$6,072,531.55	\$112,068.74	
		SUPPLIES & MATERIALS	\$0.00	\$1,094.89	-\$1,094.89	
LOCAL FUND Total		\$37,804,717.33	\$35,514,777.65	\$2,289,939.68		
DC ACCESS SYSTEM Total			\$73,735,406.48	\$68,948,989.30	\$4,786,417.18	

ELIGIBILITY & ENROLLMENT	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$4,002.84	-\$4,002.84
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$0.00	\$1,769.01	-\$1,769.01
		ENERGY COMM & BLDG RENTALS	\$0.00	\$0.00	\$0.00
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$117.83	-\$117.83
		OTHER SERVICES & CHARGES	\$0.00	-\$16,646.15	\$16,646.15
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$40,455.78	-\$40,455.78
	FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$29,699.31	-\$29,699.31
	LOCAL FUND	CONTINUING FULL TIME	\$80,482.05	\$76,700.38	\$3,781.67
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$2,732.41	\$2,732.41
		FRINGE BENEFITS - CURR PERSONNEL	\$18,188.95	\$22,647.85	-\$4,458.90
		OTHER SERVICES & CHARGES	\$0.00	-\$183.13	\$183.13
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$8,957.17	-\$8,957.17
LOCAL FUND Total		\$98,671.00	\$105,389.86	-\$6,718.86	
ELIGIBILITY & ENROLLMENT Total			\$98,671.00	\$135,089.17	-\$36,418.17
HEALTH CARE ANALYTICS	DEDICATED TAXES	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$863.99	\$863.99
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		OTHER SERVICES & CHARGES	\$0.00	-\$21,350.76	\$21,350.76
	DEDICATED TAXES Total		\$0.00	-\$22,214.75	\$22,214.75
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	-\$363.46	\$363.46
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$0.00	\$20,671.53	-\$20,671.53
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$73.85	\$73.85
		GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
		OTHER SERVICES & CHARGES	\$0.00	\$21,350.76	-\$21,350.76
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$41,584.98
	LOCAL FUND	CONTINUING FULL TIME	\$0.00	-\$444.24	\$444.24
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$7,219.04	\$7,219.04
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		GOVERNMENT SUBSIDIES & GRANTS	\$0.00	-\$66,750.15	\$66,750.15
		OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00
LOCAL FUND Total		\$0.00	-\$74,413.43	\$74,413.43	
SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$12,588.49	\$12,588.49	
SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$12,588.49	\$12,588.49	
HEALTH CARE ANALYTICS Total			\$0.00	-\$67,631.69	\$67,631.69
HEALTH CARE DELIVERY MANAGEMENT	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$311.46	-\$311.46
		CONTINUING FULL TIME	\$1,177,822.39	\$1,217,527.02	-\$39,704.63
		CONTRACTUAL SERVICES - OTHER	\$12,031,502.44	\$10,340,676.84	\$1,690,825.60
		FRINGE BENEFITS - CURR PERSONNEL	\$327,179.11	\$265,913.95	\$61,265.16
		OTHER SERVICES & CHARGES	\$72,065.19	\$31,254.06	\$40,811.13
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
		SUPPLIES & MATERIALS	\$10,664.69	\$7,587.19	\$3,077.50
	FEDERAL MEDICAID PAYMENTS Total		\$13,619,233.82	\$11,863,270.52	\$1,755,963.30
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$380.69	-\$380.69
		CONTINUING FULL TIME	\$1,823,181.35	\$1,289,883.35	\$533,298.00
		CONTRACTUAL SERVICES - OTHER	\$7,613,281.99	\$7,315,487.01	\$297,794.98
		FRINGE BENEFITS - CURR PERSONNEL	\$205,574.65	\$327,366.10	-\$121,791.45
		OTHER SERVICES & CHARGES	\$3,629.13	\$24,008.05	-\$20,378.92
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
		SUPPLIES & MATERIALS	\$812.40	\$812.36	\$0.04
	LOCAL FUND Total		\$9,646,479.52	\$8,957,937.56	\$688,541.96
	SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$88,966.70	\$88,966.70
	SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$88,966.70	\$88,966.70
	HEALTH CARE DELIVERY MANAGEMENT Total			\$23,265,713.34	\$20,732,241.38
HEALTH CARE OPERATIONS	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$499.84	-\$499.84
		CONTINUING FULL TIME	\$1,388,388.02	\$1,458,400.51	-\$70,012.49
		CONTRACTUAL SERVICES - OTHER	\$37,379,171.84	\$34,750,828.79	\$2,628,343.05
		FRINGE BENEFITS - CURR PERSONNEL	\$308,320.33	\$312,324.85	-\$4,004.52
		OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
		SUPPLIES & MATERIALS	\$585.00	\$583.39	\$1.61
	FEDERAL MEDICAID PAYMENTS Total		\$39,076,465.19	\$36,522,637.38	\$2,553,827.81
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$372.31	-\$372.31
		CONTINUING FULL TIME	\$1,229,636.26	\$1,171,698.74	\$57,937.52
		CONTRACTUAL SERVICES - OTHER	\$14,075,956.46	\$13,741,079.33	\$334,877.13
		FRINGE BENEFITS - CURR PERSONNEL	\$250,662.78	\$297,591.53	-\$46,928.75
		OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
		SUPPLIES & MATERIALS	\$715.00	\$713.05	\$1.95
	LOCAL FUND Total		\$15,556,970.50	\$15,211,454.96	\$345,515.54
	SPECIAL PURPOSE REVENUE FUNDS	ADDITIONAL GROSS PAY	\$0.00	\$238.62	-\$238.62
		CONTINUING FULL TIME	\$253,930.29	\$223,635.94	\$30,294.35
		CONTRACTUAL SERVICES - OTHER	\$472,211.37	\$472,211.33	\$0.04
FRINGE BENEFITS - CURR PERSONNEL		\$22,128.95	\$52,184.68	-\$30,055.73	
SPECIAL PURPOSE REVENUE FUNDS Total		\$748,270.61	\$748,270.57	\$0.04	
HEALTH CARE OPERATIONS Total			\$55,381,706.30	\$52,482,362.91	\$2,899,343.39
HEALTH CARE POLICY AND RESEARCH	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		FRINGE BENEFITS - CURR PERSONNEL	\$20,174.51	\$0.00	\$20,174.51
	FEDERAL GRANT FUND - FPR Total		\$20,174.51	\$0.00	\$20,174.51
	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$11,551.46	-\$11,551.46
		CONTINUING FULL TIME	\$1,501,513.62	\$1,487,966.85	\$13,546.77
		CONTINUING FULL TIME - OTHERS	\$58,818.84	\$70,349.27	-\$11,530.43
		CONTRACTUAL SERVICES - OTHER	\$648,260.07	\$446,352.31	\$201,907.76
		FRINGE BENEFITS - CURR PERSONNEL	\$177,868.77	\$388,205.92	-\$210,337.15
		OTHER SERVICES & CHARGES	\$11,437.49	\$6,372.80	\$5,064.69
		OVERTIME PAY	\$0.00	\$27,574.85	-\$27,574.85
		PURCHASES EQUIPMENT & MACHINERY	\$3,262.78	\$557.55	\$2,705.23
		SUPPLIES & MATERIALS	\$468.00	\$0.00	\$468.00
	FEDERAL MEDICAID PAYMENTS Total		\$2,401,629.57	\$2,438,931.01	-\$37,301.44
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$14,118.46	-\$14,118.46
		CONTINUING FULL TIME	\$1,716,132.82	\$1,690,958.08	\$25,174.74
		CONTINUING FULL TIME - OTHERS	\$71,889.69	\$85,982.77	-\$14,093.08
		CONTRACTUAL SERVICES - OTHER	\$764,818.31	\$363,206.14	\$401,612.17
FRINGE BENEFITS - CURR PERSONNEL		\$374,581.90	\$478,099.02	-\$103,517.12	

		OTHER SERVICES & CHARGES	\$8,897.35	\$7,788.99	\$1,108.36
		OVERTIME PAY	\$0.00	\$33,702.91	-\$33,702.91
		PURCHASES EQUIPMENT & MACHINERY	\$3,987.84	\$0.00	\$3,987.84
		SUPPLIES & MATERIALS	\$572.00	\$0.00	\$572.00
	LOCAL FUND Total		\$2,940,879.91	\$2,673,856.37	\$267,023.54
HEALTH CARE POLICY AND RESEARCH Total			\$5,362,683.99	\$5,112,787.38	\$249,896.61
HEALTH CARE REFORM AND INNOVATION	DEDICATED TAXES	ADDITIONAL GROSS PAY	\$0.00	\$1,598.29	-\$1,598.29
		CONTINUING FULL TIME	\$334,814.67	\$321,483.84	\$13,330.83
		CONTINUING FULL TIME - OTHERS	\$74,063.55	\$74,266.97	-\$203.42
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$9,516.11	\$9,516.11
		FRINGE BENEFITS - CURR PERSONNEL	\$37,798.74	\$86,366.22	-\$48,567.48
		OTHER SERVICES & CHARGES	\$1,254.09	\$1,254.09	\$0.00
		OVERTIME PAY	\$0.00	\$551.58	-\$551.58
		PURCHASES EQUIPMENT & MACHINERY	\$2,479.46	\$0.00	\$2,479.46
		SUPPLIES & MATERIALS	\$2,090.00	\$0.00	\$2,090.00
	DEDICATED TAXES Total		\$452,500.51	\$476,004.88	-\$23,504.37
	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$25,000.00	\$0.00	\$25,000.00
		CONTRACTUAL SERVICES - OTHER	\$98,560.00	\$98,560.00	\$0.00
		FRINGE BENEFITS - CURR PERSONNEL	\$60,225.10	\$0.00	\$60,225.10
		GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
	FEDERAL GRANT FUND - FPR Total		\$183,785.10	\$98,560.00	\$85,225.10
	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$2,580.32	-\$2,580.32
		CONTINUING FULL TIME	\$675,963.05	\$718,443.95	-\$42,480.90
		CONTINUING FULL TIME - OTHERS	\$101,459.70	\$98,080.34	\$3,379.36
		CONTRACTUAL SERVICES - OTHER	\$1,049,850.45	\$1,023,421.25	\$26,429.20
		FRINGE BENEFITS - CURR PERSONNEL	\$172,587.85	\$163,339.91	\$9,247.94
		GOVERNMENT SUBSIDIES & GRANTS	\$4,793,092.28	\$4,485,431.97	\$307,660.31
		OTHER SERVICES & CHARGES	\$1,026.06	\$1,026.06	\$0.00
		OVERTIME PAY	\$0.00	\$451.29	-\$451.29
		PURCHASES EQUIPMENT & MACHINERY	\$4,278.65	\$0.00	\$4,278.65
		SUPPLIES & MATERIALS	\$3,690.00	\$0.00	\$3,690.00
	FEDERAL MEDICAID PAYMENTS Total		\$6,801,948.04	\$6,492,775.09	\$309,172.95
	LOCAL FUND	CONTINUING FULL TIME	\$151,675.50	\$157,519.44	-\$5,843.94
		CONTINUING FULL TIME - OTHERS	\$49,942.75	\$18,327.41	\$31,615.34
		CONTRACTUAL SERVICES - OTHER	\$1,169,624.55	\$1,002,599.04	\$167,025.51
		FRINGE BENEFITS - CURR PERSONNEL	\$44,759.25	\$32,326.11	\$12,433.14
		GOVERNMENT SUBSIDIES & GRANTS	\$4,734,736.67	\$3,047,663.37	\$1,687,073.30
		PURCHASES EQUIPMENT & MACHINERY	\$2,750.00	\$0.00	\$2,750.00
		SUPPLIES & MATERIALS	\$220.00	\$0.00	\$220.00
	LOCAL FUND Total		\$6,153,708.72	\$4,258,435.37	\$1,895,273.35
HEALTH CARE REFORM AND INNOVATION Total			\$13,591,942.37	\$11,325,775.34	\$2,266,167.03
LONG TERM CARE PROGRAM	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
		CONTINUING FULL TIME - OTHERS	\$411,170.24	\$406,286.26	\$4,883.98
		CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$76,348.93	-\$76,348.93
		GOVERNMENT SUBSIDIES & GRANTS	\$352,135.87	\$352,135.88	-\$0.01
		OTHER SERVICES & CHARGES	\$1,785.00	\$2,143.06	-\$358.06
		PURCHASES EQUIPMENT & MACHINERY	\$327,280.80	\$327,280.80	\$0.00
	FEDERAL GRANT FUND - FPR Total		\$1,092,371.91	\$1,164,194.93	-\$71,823.02
	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$5,900.73	-\$5,900.73
		CONTINUING FULL TIME	\$2,214,079.70	\$2,110,651.88	\$103,427.82
		CONTINUING FULL TIME - OTHERS	\$45,372.15	\$14,421.24	\$30,950.91
		CONTRACTUAL SERVICES - OTHER	\$5,511,496.52	\$5,939,615.45	-\$428,118.93
		FRINGE BENEFITS - CURR PERSONNEL	\$506,325.70	\$482,819.01	\$23,506.69
		OTHER SERVICES & CHARGES	\$7,131.60	\$315.00	\$6,816.60
		OVERTIME PAY	\$0.00	\$1,710.85	-\$1,710.85
		PURCHASES EQUIPMENT & MACHINERY	\$7,050.41	\$0.00	\$7,050.41
		SUPPLIES & MATERIALS	\$741.00	\$143.60	\$597.40
	FEDERAL MEDICAID PAYMENTS Total		\$8,292,197.08	\$8,555,577.76	-\$263,380.68
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$4,211.97	-\$4,211.97
		CONTINUING FULL TIME	\$2,151,751.46	\$1,836,385.47	\$315,365.99
		CONTINUING FULL TIME - OTHERS	\$51,359.99	\$17,626.07	\$33,733.92
		CONTRACTUAL SERVICES - OTHER	\$9,031,633.84	\$6,383,107.41	\$2,648,526.43
		FRINGE BENEFITS - CURR PERSONNEL	\$339,149.04	\$467,517.29	-\$128,368.25
		OTHER SERVICES & CHARGES	\$8,702.61	\$385.00	\$8,317.61
		OVERTIME PAY	\$0.00	\$2,010.30	-\$2,010.30
		PURCHASES EQUIPMENT & MACHINERY	\$6,137.33	\$0.00	\$6,137.33
		SUPPLIES & MATERIALS	\$905.66	\$175.50	\$730.16
	LOCAL FUND Total		\$11,589,639.93	\$8,711,419.01	\$2,878,220.92
	SPECIAL PURPOSE REVENUE FUNDS	CONTINUING FULL TIME	\$0.00	-\$4,487.01	\$4,487.01
	SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$4,487.01	\$4,487.01
LONG TERM CARE PROGRAM Total			\$20,974,208.92	\$18,426,704.69	\$2,547,504.23
MMIS SYSTEM AND INFRASTRUCTURE	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$0.00	\$9,609.10	-\$9,609.10
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$83.33	\$83.33
	FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$9,525.77	-\$9,525.77
	LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$13,311.34	\$13,311.34
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00
	LOCAL FUND Total		\$0.00	-\$13,311.34	\$13,311.34
	SPECIAL PURPOSE REVENUE FUNDS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
	SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	\$0.00	\$0.00
MMIS SYSTEM AND INFRASTRUCTURE Total			\$0.00	-\$3,785.57	\$3,785.57
NO PROGRAM	FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$1,223.88	\$1,223.88
		GOVERNMENT SUBSIDIES & GRANTS	\$0.00	-\$15,195,315.00	\$15,195,315.00
		OTHER SERVICES & CHARGES	\$0.00	-\$779.05	\$779.05
	FEDERAL MEDICAID PAYMENTS Total		\$0.00	-\$15,197,317.93	\$15,197,317.93
	LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	\$656,446.14	-\$656,446.14
		OTHER SERVICES & CHARGES	\$0.00	-\$952.17	\$952.17
		P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$4,995.00	-\$4,995.00
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	-\$15,672.57	\$15,672.57
	LOCAL FUND Total		\$0.00	\$644,816.40	-\$644,816.40
NO PROGRAM Total			\$0.00	-\$14,552,501.53	\$14,552,501.53
PROGRAM OVERSIGHT	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$0.00	\$29,241.78	-\$29,241.78
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$4,334.82	-\$4,334.82

		GOVERNMENT SUBSIDIES & GRANTS	\$1,862,309.72	\$1,862,309.72	\$0.00
	FEDERAL GRANT FUND - FPR Total		\$1,862,309.72	\$1,895,886.32	-\$33,576.60
	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
		CONTINUING FULL TIME	\$159,073.91	-\$129,696.16	\$288,770.07
		CONTINUING FULL TIME - OTHERS	\$192,499.43	\$196,188.52	-\$3,689.09
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$963,033.13	\$963,033.13
		FRINGE BENEFITS - CURR PERSONNEL	\$149,253.79	\$60,263.89	\$88,989.90
		OVERTIME PAY	\$0.00	\$279.03	-\$279.03
	FEDERAL MEDICAID PAYMENTS Total		\$500,827.13	-\$835,997.85	\$1,336,824.98
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
		CONTINUING FULL TIME	\$0.00	\$185,963.63	-\$185,963.63
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$822,398.46	\$822,398.46
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		OVERTIME PAY	\$0.00	\$0.00	\$0.00
	LOCAL FUND Total		\$0.00	-\$636,434.83	\$636,434.83
	SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$7,562.06	\$7,562.06
	SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$7,562.06	\$7,562.06
PROGRAM OVERSIGHT Total			\$2,363,136.85	\$415,891.58	\$1,947,245.27
PROVIDER SERVICES	DEDICATED TAXES	CONTRACTUAL SERVICES - OTHER	\$110,000.00	\$110,000.00	\$0.00
		GOVERNMENT SUBSIDIES & GRANTS	\$237,591,707.04	\$234,362,409.04	\$3,229,298.00
	DEDICATED TAXES Total		\$237,701,707.04	\$234,472,409.04	\$3,229,298.00
	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$314,775.00	\$54,801.06	\$259,973.94
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$17.14	\$17.14
		GOVERNMENT SUBSIDIES & GRANTS	\$3,010,201,226.48	\$3,013,333,869.51	-\$3,132,643.03
	FEDERAL MEDICAID PAYMENTS Total		\$3,010,516,001.48	\$3,013,388,653.43	-\$2,872,651.95
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
		CONTINUING FULL TIME - OTHERS	\$53,714.70	\$53,714.70	\$0.00
		CONTRACTUAL SERVICES - OTHER	\$859,524.89	\$706,412.39	\$153,112.50
		FRINGE BENEFITS - CURR PERSONNEL	\$691.92	\$691.92	\$0.00
		GOVERNMENT SUBSIDIES & GRANTS	\$948,047,263.65	\$956,972,356.56	-\$8,925,092.91
	LOCAL FUND Total		\$948,961,195.16	\$957,733,175.57	-\$8,771,980.41
	SPECIAL PURPOSE REVENUE FUNDS	GOVERNMENT SUBSIDIES & GRANTS	\$1,102,749.00	\$1,102,749.00	\$0.00
	SPECIAL PURPOSE REVENUE FUNDS Total		\$1,102,749.00	\$1,102,749.00	\$0.00
PROVIDER SERVICES Total			\$4,198,281,652.68	\$4,206,696,987.04	-\$8,415,334.36
Grand Total			\$4,440,179,423.94	\$4,411,223,736.48	\$28,955,687.46

\$14,552,501.53	\$14,552,501.53	\$14,552,501.53
\$14,552,501.53	\$14,552,501.53	\$14,552,501.53
\$14,552,501.53	\$14,552,501.53	\$14,552,501.53

FY 2025

Program (Parent Level 2) Description	Cost Center	Cost Center Description	Appropriated Fund Description		Account Group (Parent Level 1) Description	Sum of Total Budget	Sum of Expenditure	Sum of Available Budget
AGENCY FINANCIAL OPERATIONS	0	NO COST CENTER	FEDERAL MEDICAID PAYMENTS		GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$0.00	\$0.00	
					\$0.00	\$0.00	\$0.00	
	10001	BUDGET DIVISION	FEDERAL MEDICAID PAYMENTS		CONTINUING FULL TIME	\$307,292.66	\$323,293.06	-\$16,000.40
					FRINGE BENEFITS - CURR PERSONNEL	\$68,218.98	\$82,695.20	-\$14,476.22
					PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
					FEDERAL MEDICAID PAYMENTS Total	\$375,511.64	\$405,988.26	-\$30,476.62
			LOCAL FUND		CONTINUING FULL TIME	\$375,579.95	\$355,103.74	\$20,476.21
					FRINGE BENEFITS - CURR PERSONNEL	\$83,378.75	\$101,914.57	-\$18,535.82
						\$0.00	\$0.00	\$0.00
					LOCAL FUND Total	\$458,958.70	\$457,018.31	\$1,940.39
						\$834,470.34	\$863,006.57	-\$28,536.23
	10002	ACCOUNTING DIVISION	DEDICATED TAXES		CONTINUING FULL TIME	\$36,984.96	\$27,828.68	\$9,156.28
					CONTRACTUAL SERVICES - OTHER	\$209,678.30	\$184,281.50	\$25,396.80
					FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$9,156.28	-\$9,156.28
					DEDICATED TAXES Total	\$246,663.26	\$221,266.46	\$25,396.80
			FEDERAL MEDICAID PAYMENTS		CONTINUING FULL TIME	\$533,445.22	\$513,885.79	\$19,559.43
					CONTRACTUAL SERVICES - OTHER	\$201,378.10	\$1,555,195.71	-\$1,353,817.61
					FRINGE BENEFITS - CURR PERSONNEL	\$118,424.84	\$109,309.74	\$9,115.10
					OTHER SERVICES & CHARGES	\$182,144.37	\$87,395.51	\$94,748.86
					SUPPLIES & MATERIALS	\$0.00	\$0.00	\$0.00
					FEDERAL MEDICAID PAYMENTS Total	\$1,035,392.53	\$2,265,786.75	-\$1,230,394.22
			LOCAL FUND		CONTINUING FULL TIME	\$594,980.56	\$535,422.45	\$59,558.11
					CONTRACTUAL SERVICES - OTHER	\$2,354,006.97	\$1,645,104.65	\$708,902.32
					FRINGE BENEFITS - CURR PERSONNEL	\$132,085.69	\$125,579.14	\$6,506.55
					OTHER SERVICES & CHARGES	\$222,620.89	\$92,132.26	\$130,488.63
					PURCHASES EQUIPMENT & MACHINERY	\$0.00	-\$91.68	\$91.68
					SUPPLIES & MATERIALS	\$0.00	\$0.00	\$0.00
					LOCAL FUND Total	\$3,303,694.11	\$2,398,146.82	\$905,547.29
						\$4,585,749.90	\$4,885,200.03	-\$299,450.13
	10003	ACFO DIVISION	FEDERAL MEDICAID PAYMENTS		CONTINUING FULL TIME	\$135,168.87	\$142,981.00	-\$7,812.13
					FRINGE BENEFITS - CURR PERSONNEL	\$30,007.49	\$24,412.04	\$5,595.45
					PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
					FEDERAL MEDICAID PAYMENTS Total	\$165,176.36	\$167,393.04	-\$2,216.68
			LOCAL FUND		CONTINUING FULL TIME	\$165,206.40	\$158,276.78	\$6,929.62
					FRINGE BENEFITS - CURR PERSONNEL	\$36,675.82	\$30,006.71	\$6,669.11
					PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
					LOCAL FUND Total	\$201,882.22	\$188,283.49	\$13,598.73
				\$367,058.58	\$355,676.53	\$11,382.05		
	10070	BUDGET DIVISION - HSSC	FEDERAL MEDICAID PAYMENTS		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
					FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$0.00	\$0.00
			LOCAL FUND		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
					LOCAL FUND Total	\$0.00	\$0.00	\$0.00
						\$0.00	\$0.00	\$0.00
	10071	ACCOUNTING DIVISION - HSSC	FEDERAL MEDICAID PAYMENTS		CONTRACTUAL SERVICES - OTHER	\$0.00	\$7.29	-\$7.29
					OTHER SERVICES & CHARGES	\$67.50	\$67.50	\$0.00
					SUPPLIES & MATERIALS	\$59.54	\$59.54	\$0.00
					FEDERAL MEDICAID PAYMENTS Total	\$127.04	\$134.33	-\$7.29
			LOCAL FUND		OTHER SERVICES & CHARGES	\$82.50	\$82.50	\$0.00
					SUPPLIES & MATERIALS	\$72.78	\$72.78	\$0.00
					LOCAL FUND Total	\$155.28	\$155.28	\$0.00
			SPECIAL PURPOSE REVENUE FUNDS		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$7.29	\$7.29
					SPECIAL PURPOSE REVENUE FUNDS Total	\$0.00	-\$7.29	\$7.29
						\$282.32	\$282.32	\$0.00
	10072	ACFO DIVISION - HSSC	FEDERAL MEDICAID PAYMENTS		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
					FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$0.00	\$0.00
			LOCAL FUND		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
					LOCAL FUND Total	\$0.00	\$0.00	\$0.00
						\$0.00	\$0.00	\$0.00
	10086	P-CARD CLEARING	FEDERAL MEDICAID PAYMENTS		P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$0.00	\$0.00
					FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$0.00	\$0.00
LOCAL FUND			P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$0.00	\$0.00		
			LOCAL FUND Total	\$0.00	\$0.00	\$0.00		
SPECIAL PURPOSE REVENUE FUNDS			P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$0.00	\$0.00		
			SPECIAL PURPOSE REVENUE FUNDS Total	\$0.00	\$0.00	\$0.00		
				\$0.00	\$0.00	\$0.00		
			P-CARD CLEARING Total		\$0.00	\$0.00	\$0.00	
AGENCY FINANCIAL OPERATIONS Total						\$5,787,561.14	\$6,104,165.45	-\$316,604.31

AGENCY MANAGEMENT PROGRAM	70156	INVESTIGATION AND COMPLIANCE DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$675.00	-\$675.00
				CONTINUING FULL TIME	\$376,516.29	\$467,401.63	-\$90,885.34
				CONTRACTUAL SERVICES - OTHER	\$37,867.50	\$18,094.23	\$19,773.27
				FRINGE BENEFITS - CURR PERSONNEL	\$72,786.62	\$80,173.60	-\$7,386.98
			FEDERAL MEDICAID PAYMENTS Total		\$487,170.41	\$566,344.46	-\$79,174.05
			LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$825.00	-\$825.00
				CONTINUING FULL TIME	\$460,186.58	\$495,334.46	-\$35,147.88
				CONTRACTUAL SERVICES - OTHER	\$46,282.50	\$2,393.48	\$43,889.02
				FRINGE BENEFITS - CURR PERSONNEL	\$88,961.41	\$98,485.74	-\$9,524.33
			LOCAL FUND Total		\$595,430.49	\$597,038.68	-\$1,608.19
INVESTIGATION AND COMPLIANCE DIVISION Total					\$1,082,600.90	\$1,163,383.14	-\$80,782.24
70157	SURVEILLANCE AND UTILIZATION DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$3,578.69	-\$3,578.69	
			CONTINUING FULL TIME	\$674,226.57	\$602,323.58	\$71,902.99	
			CONTINUING FULL TIME - OTHERS	\$159,884.59	\$84,267.82	\$75,616.77	
			CONTRACTUAL SERVICES - OTHER	\$100,875.00	\$35,554.18	\$65,320.82	
			FRINGE BENEFITS - CURR PERSONNEL	\$185,172.67	\$186,901.78	-\$1,729.11	
		FEDERAL MEDICAID PAYMENTS Total		\$1,120,158.83	\$912,626.05	\$207,532.78	
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$1,373.96	-\$1,373.96	
			CONTINUING FULL TIME	\$471,342.70	\$423,037.15	\$48,305.55	
			CONTINUING FULL TIME - OTHERS	\$191,755.55	\$102,993.92	\$88,761.63	
			CONTRACTUAL SERVICES - OTHER	\$56,625.00	\$23,383.22	\$33,241.78	
	FRINGE BENEFITS - CURR PERSONNEL	\$131,654.51	\$153,595.81	-\$21,941.30			
LOCAL FUND Total		\$851,377.76	\$704,384.06	\$146,993.70			
SPECIAL PURPOSE REVENUE FUNDS		CONTINUING FULL TIME	\$0.00	\$7,084.71	\$7,084.71		
SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$7,084.71	\$7,084.71			
SURVEILLANCE AND UTILIZATION DIVISION Total					\$1,971,536.59	\$1,609,925.40	\$361,611.19
70158	PROGRAM INTEGRITY SUPPORT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$959.48	-\$959.48	
			CONTINUING FULL TIME	\$599,860.83	\$570,432.92	\$29,427.91	
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$12,722.66	-\$12,722.66	
			FRINGE BENEFITS - CURR PERSONNEL	\$133,169.10	\$112,213.64	\$20,955.46	
			OTHER SERVICES & CHARGES	\$1,765.60	\$1,771.00	-\$5.40	
			PURCHASES EQUIPMENT & MACHINERY	\$640.81	\$640.81	\$0.00	
			SUPPLIES & MATERIALS	\$1,092.57	\$1,091.03	\$1.54	
		FEDERAL MEDICAID PAYMENTS Total		\$736,528.91	\$609,831.54	\$126,697.37	
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$1,172.68	-\$1,172.68	
			CONTINUING FULL TIME	\$726,948.36	\$606,886.76	\$120,061.60	
	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$12,722.66	\$12,722.66			
	FRINGE BENEFITS - CURR PERSONNEL	\$137,200.52	\$137,902.44	-\$701.92			
	OTHER SERVICES & CHARGES	\$2,157.97	\$2,164.57	-\$6.60			
	PURCHASES EQUIPMENT & MACHINERY	\$783.22	\$783.22	\$0.00			
	SUPPLIES & MATERIALS	\$1,335.37	\$1,333.43	\$1.94			
LOCAL FUND Total		\$868,425.44	\$737,520.44	\$130,905.00			
PROGRAM INTEGRITY SUPPORT DIVISION Total					\$1,604,954.35	\$1,437,351.98	\$167,602.37
70267	AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION	DEDICATED TAXES	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00	
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$1,289.62	\$1,289.62	
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00	
			OVERTIME PAY	\$0.00	\$0.00	\$0.00	
		DEDICATED TAXES Total		\$0.00	-\$1,289.62	\$1,289.62	
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00	
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$113,940.80	-\$113,940.80	
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$15.11	\$15.11	
			OVERTIME PAY	\$0.00	\$0.00	\$0.00	
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$113,925.69	-\$113,925.69	
LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$112,651.18	\$112,651.18			
	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00			
LOCAL FUND Total		\$0.00	-\$112,651.18	\$112,651.18			
AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION Total					\$0.00	-\$15.11	\$15.11
70274	OFFICE OF THE OMBUDSMAN - HT0	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$2,154.32	-\$2,154.32	
			CONTINUING FULL TIME	\$1,233,434.50	\$1,058,436.39	\$174,998.11	
			CONTINUING FULL TIME - OTHERS	\$30,406.50	\$74,019.23	-\$43,612.73	
			CONTRACTUAL SERVICES - OTHER	\$608,570.24	\$403,078.72	\$205,491.52	
			FRINGE BENEFITS - CURR PERSONNEL	\$280,572.70	\$235,240.96	\$45,331.74	
			OTHER SERVICES & CHARGES	\$4,395.15	\$14,183.97	-\$9,788.82	
			PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00	
			SUPPLIES & MATERIALS	\$1,429.85	\$1,429.85	\$0.00	
		FEDERAL MEDICAID PAYMENTS Total		\$2,158,808.94	\$1,788,543.44	\$370,265.50	
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	-\$34,910.65	\$34,910.65	
	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$25,696.76	\$25,696.76			
	PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00			
LOCAL FUND Total		\$0.00	-\$60,607.41	\$60,607.41			
SPECIAL PURPOSE REVENUE FUNDS	ADDITIONAL GROSS PAY	\$0.00	\$1,633.06	-\$1,633.06			
	CONTINUING FULL TIME	\$1,190,887.49	\$1,016,829.31	\$174,058.18			
	CONTINUING FULL TIME - OTHERS	\$37,163.50	\$90,467.80	-\$53,304.30			
	CONTRACTUAL SERVICES - OTHER	\$337,335.11	\$364,872.72	-\$27,537.61			
	FRINGE BENEFITS - CURR PERSONNEL	\$256.12	\$248,688.26	-\$248,432.14			
	OTHER SERVICES & CHARGES	\$5,371.85	-\$4,416.97	\$9,788.82			
	SUPPLIES & MATERIALS	\$1,747.60	\$1,747.60	\$0.00			
SPECIAL PURPOSE REVENUE FUNDS Total		\$1,572,761.67	\$1,719,821.78	-\$147,060.11			
OFFICE OF THE OMBUDSMAN - HT0 Total					\$3,731,570.61	\$3,447,757.81	\$283,812.80

70275	OFFICE OF THE DIRECTOR'S ADMINISTRATIVE OFFICE	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$11,971.62	-\$11,971.62
			CONTINUING FULL TIME	\$392,897.67	\$252,731.68	\$140,165.99
			CONTINUING FULL TIME - OTHERS	\$96,687.49	\$110,738.46	-\$14,050.97
			CONTRACTUAL SERVICES - OTHER	\$36,717.75	\$1,059.35	\$35,658.40
			FRINGE BENEFITS - CURR PERSONNEL	\$109,838.09	\$62,184.83	\$47,653.26
			OTHER SERVICES & CHARGES	\$1,962.09	\$2,068.42	-\$106.33
			PURCHASES EQUIPMENT & MACHINERY	\$906.39	\$906.39	\$0.00
			SUPPLIES & MATERIALS	\$348.13	\$348.13	\$0.00
			FEDERAL MEDICAID PAYMENTS Total	\$639,357.61	\$442,008.88	\$197,348.73
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$14,631.97	-\$14,631.97
			CONTINUING FULL TIME	\$469,620.32	\$269,977.77	\$199,642.55
			CONTINUING FULL TIME - OTHERS	\$118,173.60	\$135,347.00	-\$17,173.40
			CONTRACTUAL SERVICES - OTHER	\$27,858.65	-\$1,059.35	\$28,918.00
			FRINGE BENEFITS - CURR PERSONNEL	\$86,548.82	\$76,406.56	\$10,142.26
			OTHER SERVICES & CHARGES	\$2,398.09	\$2,490.76	-\$92.67
			PURCHASES EQUIPMENT & MACHINERY	\$1,107.81	\$1,107.81	\$0.00
			SUPPLIES & MATERIALS	\$425.51	\$425.51	\$0.00
			LOCAL FUND Total	\$706,132.80	\$499,328.03	\$206,804.77
		OFFICE OF THE DIRECTOR'S ADMINISTRATIVE OFFICE Total		\$1,345,490.41	\$941,336.91	\$404,153.50
70277	COMPLIANCE DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$16,200.00	\$0.00	\$16,200.00
		FEDERAL MEDICAID PAYMENTS Total		\$16,200.00	\$0.00	\$16,200.00
		LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$12,307.09	\$0.00	\$12,307.09
		LOCAL FUND Total		\$12,307.09	\$0.00	\$12,307.09
		COMPLIANCE DIVISION - HT0 Total		\$28,507.09	\$0.00	\$28,507.09
70278	SUPPORT SERVICES DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$110.27	-\$110.27
			CONTINUING FULL TIME	\$136,701.57	\$162,811.55	-\$26,109.98
			CONTINUING FULL TIME - OTHERS	\$29,702.11	\$26,477.10	\$3,225.01
			CONTRACTUAL SERVICES - OTHER	\$758,073.31	\$588,753.81	\$169,319.50
			ENERGY COMM & BLDG RENTALS	\$575,126.86	\$369,300.83	\$205,826.03
			FRINGE BENEFITS - CURR PERSONNEL	\$34,781.13	\$35,474.64	-\$693.51
			OTHER SERVICES & CHARGES	\$82,775.57	\$82,448.35	\$327.22
			OVERTIME PAY	\$0.00	\$143.27	-\$143.27
			SECURITY SERVICES	\$55,187.72	\$51,778.68	\$3,409.04
			FEDERAL MEDICAID PAYMENTS Total	\$1,672,348.27	\$1,317,298.50	\$355,049.77
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$134.77	-\$134.77
			CONTINUING FULL TIME	\$211,294.27	\$175,733.21	\$35,561.06
			CONTINUING FULL TIME - OTHERS	\$36,302.57	\$32,360.90	\$3,941.67
			CONTRACTUAL SERVICES - OTHER	\$901,802.60	\$867,293.02	\$34,509.58
			ENERGY COMM & BLDG RENTALS	\$702,932.83	\$653,707.42	\$49,225.41
			FRINGE BENEFITS - CURR PERSONNEL	\$54,966.51	\$43,628.51	\$11,338.00
			OTHER SERVICES & CHARGES	\$89,056.13	\$91,680.05	-\$2,623.92
			OVERTIME PAY	\$0.00	\$175.12	-\$175.12
			SECURITY SERVICES	\$67,451.66	\$27,594.50	\$39,857.16
			LOCAL FUND Total	\$2,063,806.57	\$1,892,307.50	\$171,499.07
		SUPPORT SERVICES DIVISION - HT0 Total		\$3,736,154.84	\$3,209,606.00	\$526,548.84
70279	HUMAN RESOURCES DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$42.85	-\$42.85
			CONTINUING FULL TIME	\$341,673.99	\$299,115.73	\$42,558.26
			CONTINUING FULL TIME - OTHERS	\$26,404.65	\$26,477.07	-\$72.42
			CONTRACTUAL SERVICES - OTHER	\$233,328.12	\$8,328.12	\$225,000.00
			FRINGE BENEFITS - CURR PERSONNEL	\$79,876.94	\$76,129.56	\$3,747.38
			OTHER SERVICES & CHARGES	\$0.00	\$156.72	-\$156.72
			OVERTIME PAY	\$0.00	\$373.47	-\$373.47
			FEDERAL MEDICAID PAYMENTS Total	\$681,283.70	\$410,623.52	\$270,660.18
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$52.38	-\$52.38
			CONTINUING FULL TIME	\$416,361.78	\$326,888.34	\$89,473.44
			CONTINUING FULL TIME - OTHERS	\$32,272.35	\$32,360.93	-\$88.58
			CONTRACTUAL SERVICES - OTHER	\$285,178.82	\$10,178.82	\$275,000.00
			FRINGE BENEFITS - CURR PERSONNEL	\$88,140.96	\$93,678.38	-\$5,537.42
			OTHER SERVICES & CHARGES	\$0.00	\$749.44	-\$749.44
			OVERTIME PAY	\$0.00	\$456.46	-\$456.46
			LOCAL FUND Total	\$821,953.91	\$464,364.75	\$357,589.16
		HUMAN RESOURCES DIVISION - HT0 Total		\$1,503,237.61	\$874,988.27	\$628,249.34
70280	INFORMATION TECHNOLOGY DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$820,792.57	\$971,532.82	-\$150,740.25
			CONTINUING FULL TIME - OTHERS	\$0.00	\$24,204.77	-\$24,204.77
			CONTRACTUAL SERVICES - OTHER	\$5,672,112.92	\$3,610,885.39	\$2,061,227.53
			FRINGE BENEFITS - CURR PERSONNEL	\$187,256.12	\$230,351.90	-\$43,095.78
			OTHER SERVICES & CHARGES	\$133,406.89	\$118,487.21	\$14,919.68
			PURCHASES EQUIPMENT & MACHINERY	\$275,143.89	\$254,993.64	\$20,150.25
			SUPPLIES & MATERIALS	\$435.72	\$268.41	\$167.31
			FEDERAL MEDICAID PAYMENTS Total	\$7,089,148.11	\$5,210,724.14	\$1,878,423.97
		LOCAL FUND	CONTINUING FULL TIME	\$917,241.87	\$994,906.59	-\$77,664.72
			CONTINUING FULL TIME - OTHERS	\$0.00	\$29,583.56	-\$29,583.56
			CONTRACTUAL SERVICES - OTHER	\$2,630,148.26	\$2,869,852.49	-\$239,704.23
			FRINGE BENEFITS - CURR PERSONNEL	\$186,357.15	\$261,311.05	-\$74,953.90
			OTHER SERVICES & CHARGES	\$163,052.86	\$167,620.72	-\$4,567.86
			PURCHASES EQUIPMENT & MACHINERY	\$336,286.94	\$359,568.53	-\$23,281.59
			SUPPLIES & MATERIALS	\$532.52	\$706.23	-\$173.71
			LOCAL FUND Total	\$4,233,619.60	\$4,683,549.17	-\$449,929.57
		INFORMATION TECHNOLOGY DIVISION - HT0 Total		\$11,322,767.71	\$9,894,273.31	\$1,428,494.40
70281	CONTRACTS DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$481.58	-\$481.58
			CONTINUING FULL TIME	\$762,508.18	\$681,916.36	\$80,591.82
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$167,191.77	\$150,747.96	\$16,443.81
		FEDERAL MEDICAID PAYMENTS Total		\$929,699.95	\$833,145.90	\$96,554.05
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$588.60	-\$588.60
			CONTINUING FULL TIME	\$931,954.43	\$748,425.99	\$183,528.44
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$204,345.49	\$184,366.23	\$19,979.26
			LOCAL FUND Total	\$1,136,299.92	\$933,380.82	\$202,919.10
		CONTRACTS DIVISION Total		\$2,065,999.87	\$1,766,526.72	\$299,473.15
70282	OFFICE OF THE GENERAL COUNSEL - HT0	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$1,152.01	-\$1,152.01

			CONTINUING FULL TIME	\$522,215.52	\$341,710.36	\$180,505.16
			CONTINUING FULL TIME - OTHERS	\$74,991.48	\$54,515.38	\$20,476.10
			FRINGE BENEFITS - CURR PERSONNEL	\$131,035.55	\$105,416.20	\$25,619.35
			OTHER SERVICES & CHARGES	\$3,642.00	\$0.00	\$3,642.00
			PURCHASES EQUIPMENT & MACHINERY	\$768.00	\$768.00	\$0.00
			SUPPLIES & MATERIALS	\$675.00	\$0.00	\$675.00
			FEDERAL MEDICAID PAYMENTS Total	\$733,327.55	\$503,561.95	\$229,765.60
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$1,408.01	-\$1,408.01
			CONTINUING FULL TIME	\$589,669.35	\$548,779.26	\$40,890.09
			FRINGE BENEFITS - CURR PERSONNEL	\$106,205.58	\$103,682.98	\$2,522.60
			OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00
			PURCHASES EQUIPMENT & MACHINERY	\$938.67	\$938.67	\$0.00
			LOCAL FUND Total	\$696,813.60	\$654,808.92	\$42,004.68
		OFFICE OF THE GENERAL COUNSEL - HT0 Total		\$1,430,141.15	\$1,158,370.87	\$271,770.28
70283	OFFICE OF THE DEPUTY DIRECTOR, FINANCE	DEDICATED TAXES	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
			DEDICATED TAXES Total	\$0.00	\$0.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$10,083.04	-\$10,083.04
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$125.61	\$125.61
			FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$9,957.43	-\$9,957.43
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$64,648.11	\$64,648.11
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
			LOCAL FUND Total	\$0.00	-\$64,648.11	\$64,648.11
		OFFICE OF THE DEPUTY DIRECTOR, FINANCE Total		\$0.00	-\$54,690.68	\$54,690.68
70321	DCAS UNIT	FEDERAL GRANT FUND - FPR	PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
			FEDERAL GRANT FUND - FPR Total	\$0.00	\$0.00	\$0.00
		DCAS UNIT Total		\$0.00	\$0.00	\$0.00
70479	HOSPITAL SUPPORT	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$97,208.79	-\$97,208.79
			LOCAL FUND Total	\$0.00	\$97,208.79	-\$97,208.79
		HOSPITAL SUPPORT Total		\$0.00	\$97,208.79	-\$97,208.79
70489	CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$176.99	-\$176.99
			CONTINUING FULL TIME	\$297,414.70	\$458,417.33	-\$161,002.63
			CONTRACTUAL SERVICES - OTHER	\$48,486.87	\$51,460.06	-\$2,973.19
			FRINGE BENEFITS - CURR PERSONNEL	\$66,386.07	\$89,567.96	-\$23,181.89
			OTHER SERVICES & CHARGES	\$85,327.57	\$20,216.36	\$65,111.21
			PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
			SUPPLIES & MATERIALS	\$13,340.41	\$12,772.21	\$568.20
			FEDERAL MEDICAID PAYMENTS Total	\$510,955.62	\$632,610.91	-\$121,655.29
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$216.33	-\$216.33
			CONTINUING FULL TIME	\$363,506.89	\$504,041.27	-\$140,534.38
			CONTRACTUAL SERVICES - OTHER	\$405,064.73	\$347,600.97	\$57,463.76
			ENERGY COMM & BLDG RENTALS	\$0.00	\$1,272.42	-\$1,272.42
			FRINGE BENEFITS - CURR PERSONNEL	\$81,138.53	\$110,114.89	-\$28,976.36
			OTHER SERVICES & CHARGES	\$129,733.38	\$55,436.88	\$74,296.50
			P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	-\$4,995.00	\$4,995.00
			PURCHASES EQUIPMENT & MACHINERY	\$596.59	\$596.59	\$0.00
			SUPPLIES & MATERIALS	\$16,304.94	\$13,853.44	\$2,451.50
			LOCAL FUND Total	\$996,345.06	\$1,028,137.79	-\$31,792.73
		CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS Total		\$1,507,300.68	\$1,660,748.70	-\$153,448.02
70528	OFFICE OF CHIEF MEDICAL OFFICER	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
			FEDERAL GRANT FUND - FPR Total	\$0.00	\$0.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$2,390.62	-\$2,390.62
			CONTINUING FULL TIME	\$778,705.08	\$736,411.78	\$42,293.30
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$391,234.16	-\$391,234.16
			FRINGE BENEFITS - CURR PERSONNEL	\$172,872.54	\$157,703.95	\$15,168.59
			FEDERAL MEDICAID PAYMENTS Total	\$951,577.62	\$1,287,740.51	-\$336,162.89
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$796.88	-\$796.88
			CONTINUING FULL TIME	\$374,482.32	\$355,793.62	\$18,688.70
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$2,675.04	\$2,675.04
			FRINGE BENEFITS - CURR PERSONNEL	\$62,051.75	\$78,380.52	-\$16,328.77
			LOCAL FUND Total	\$436,534.07	\$432,295.98	\$4,238.09
		OFFICE OF CHIEF MEDICAL OFFICER Total		\$1,388,111.69	\$1,720,036.49	-\$331,924.80

70530	SENIOR DEPUTY DIRECTOR MEDICAID DIRECTOR DASH ADMISTRATIVE FUNCTIONS	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$321,513.68	\$278,980.49	\$42,533.19
			CONTINUING FULL TIME - OTHERS	\$20,186.55	\$28,372.52	-\$8,185.97
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$75,857.45	\$72,844.98	\$3,012.47
			OTHER SERVICES & CHARGES	\$2,793.26	\$3,215.73	-\$422.47
			PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
			SUPPLIES & MATERIALS	\$2,255.64	\$2,255.15	\$0.49
		FEDERAL MEDICAID PAYMENTS Total		\$422,606.58	\$385,668.87	\$36,937.71
		LOCAL FUND	CONTINUING FULL TIME	\$392,961.15	\$301,568.00	\$91,393.15
			CONTINUING FULL TIME - OTHERS	\$16,878.13	\$34,677.55	-\$17,799.42
			CONTRACTUAL SERVICES - OTHER	\$600,000.09	\$0.00	\$600,000.09
			FRINGE BENEFITS - CURR PERSONNEL	\$61,470.15	\$89,559.30	-\$28,089.15
			OTHER SERVICES & CHARGES	\$3,414.00	\$3,595.44	-\$181.44
			PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
			SUPPLIES & MATERIALS	\$2,756.89	\$2,756.18	\$0.71
		LOCAL FUND Total		\$1,077,480.41	\$432,156.47	\$645,323.94
		SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00
		SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	\$0.00	\$0.00
	SENIOR DEPUTY DIRECTOR MEDICAID DIRECTOR DASH ADMISTRATIVE FUNCTIONS Total			\$1,500,086.99	\$817,825.34	\$682,261.65
70536	ANALYTIC REPORTING DIVISION	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		FEDERAL GRANT FUND - FPR Total		\$0.00	\$0.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$234,624.38	\$186,268.11	\$48,356.27
			CONTRACTUAL SERVICES - OTHER	\$124,479.34	\$117,861.61	\$6,617.73
			FRINGE BENEFITS - CURR PERSONNEL	\$52,086.63	\$45,586.25	\$6,500.38
			OTHER SERVICES & CHARGES	\$3,210.75	\$0.00	\$3,210.75
			SUPPLIES & MATERIALS	\$731.25	\$728.10	\$3.15
		FEDERAL MEDICAID PAYMENTS Total		\$415,132.35	\$350,444.07	\$64,688.28
		LOCAL FUND	CONTINUING FULL TIME	\$279,179.36	\$196,796.85	\$82,382.51
			CONTRACTUAL SERVICES - OTHER	\$134,522.63	\$109,105.51	\$25,417.12
			FRINGE BENEFITS - CURR PERSONNEL	\$33,174.48	\$56,130.24	-\$22,955.76
			OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00
			SUPPLIES & MATERIALS	\$893.75	\$889.88	\$3.87
		LOCAL FUND Total		\$447,770.22	\$362,922.48	\$84,847.74
	ANALYTIC REPORTING DIVISION Total			\$862,902.57	\$713,366.55	\$149,536.02
70537	RESEARCH AND DEVELOPMENT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$12.12	-\$12.12
			CONTINUING FULL TIME	\$226,004.24	\$246,280.58	-\$20,276.34
			CONTINUING FULL TIME - OTHERS	\$0.00	\$26,942.49	-\$26,942.49
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$5,065.32	-\$5,065.32
			FRINGE BENEFITS - CURR PERSONNEL	\$50,941.88	\$44,260.67	\$6,681.21
		FEDERAL MEDICAID PAYMENTS Total		\$276,946.12	\$322,561.18	-\$45,615.06
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$14.81	-\$14.81
			CONTINUING FULL TIME	\$322,247.16	\$199,444.12	\$122,803.04
			CONTINUING FULL TIME - OTHERS	\$0.00	\$32,929.40	-\$32,929.40
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$5,065.31	\$5,065.31
			FRINGE BENEFITS - CURR PERSONNEL	-\$1,847.42	\$54,275.20	-\$56,122.62
		LOCAL FUND Total		\$320,399.74	\$281,598.22	\$38,801.52
	RESEARCH AND DEVELOPMENT DIVISION Total			\$597,345.86	\$604,159.40	-\$6,813.54
70538	SENIOR DEPUTY DIRECTOR FINANCE ADMINSTRATIVE FUNCTIONS	DEDICATED TAXES	CONTINUING FULL TIME	\$56,594.44	\$22,351.46	\$34,242.98
			FRINGE BENEFITS - CURR PERSONNEL	\$12,564.17	\$4,630.00	\$7,934.17
		DEDICATED TAXES Total		\$69,158.61	\$26,981.46	\$42,177.15
		FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		FEDERAL GRANT FUND - FPR Total		\$0.00	\$0.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$335,652.74	\$238,463.72	\$97,189.02
			CONTINUING FULL TIME - OTHERS	\$15,203.25	\$10,546.27	\$4,656.98
			CONTRACTUAL SERVICES - OTHER	\$1,236,647.13	\$769,395.94	\$467,251.19
			FRINGE BENEFITS - CURR PERSONNEL	\$77,890.03	\$60,493.13	\$17,396.90
			OTHER SERVICES & CHARGES	\$2,120.42	\$1,659.32	\$461.10
			PURCHASES EQUIPMENT & MACHINERY	\$1,578.71	\$1,578.71	\$0.00
			SUPPLIES & MATERIALS	\$2,255.64	\$2,254.13	\$1.51
		FEDERAL MEDICAID PAYMENTS Total		\$1,671,347.92	\$1,084,391.22	\$586,956.70
		LOCAL FUND	CONTINUING FULL TIME	\$353,646.86	\$241,509.64	\$112,137.22
			CONTRACTUAL SERVICES - OTHER	\$1,498,640.95	\$821,265.10	\$677,375.85
			FRINGE BENEFITS - CURR PERSONNEL	\$78,509.61	\$68,896.35	\$9,613.26
			OTHER SERVICES & CHARGES	\$2,591.61	\$1,910.71	\$680.90
			PURCHASES EQUIPMENT & MACHINERY	\$1,929.54	\$1,929.54	\$0.00
			SUPPLIES & MATERIALS	\$2,756.89	\$2,755.02	\$1.87
		LOCAL FUND Total		\$1,938,075.46	\$1,138,266.36	\$799,809.10
		SPECIAL PURPOSE REVENUE FUNDS	CONTINUING FULL TIME - OTHERS	\$18,581.75	\$12,890.00	\$5,691.75
			FRINGE BENEFITS - CURR PERSONNEL	\$4,125.15	\$1,009.29	\$3,115.86
		SPECIAL PURPOSE REVENUE FUNDS Total		\$22,706.90	\$13,899.29	\$8,807.61
	SENIOR DEPUTY DIRECTOR FINANCE ADMINSTRATIVE FUNCTIONS Total			\$3,701,288.89	\$2,263,538.33	\$1,437,750.56
70539	OFFICE OF RATES REIMBURSEMENT AND FINANCIAL ANALYSIS	DEDICATED TAXES	CONTINUING FULL TIME	\$127,682.74	\$137,748.95	-\$10,066.21
			FRINGE BENEFITS - CURR PERSONNEL	\$13,430.88	\$25,713.99	-\$12,283.11
		DEDICATED TAXES Total		\$141,113.62	\$163,462.94	-\$22,349.32
		FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$3,338.02	-\$3,338.02
			CONTINUING FULL TIME	\$644,336.04	\$701,565.65	-\$57,229.61
			CONTINUING FULL TIME - OTHERS	\$81,724.50	\$81,948.87	-\$224.37
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$17,563.52	-\$17,563.52
			FRINGE BENEFITS - CURR PERSONNEL	\$161,185.44	\$216,767.43	-\$55,581.99
		FEDERAL MEDICAID PAYMENTS Total		\$887,245.98	\$1,021,183.49	-\$133,937.51
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$4,079.80	-\$4,079.80
			CONTINUING FULL TIME	\$659,839.10	\$630,074.96	\$29,764.14
			CONTINUING FULL TIME - OTHERS	\$99,885.50	\$100,160.08	-\$274.58
			FRINGE BENEFITS - CURR PERSONNEL	\$168,658.86	\$239,565.07	-\$70,906.21
		LOCAL FUND Total		\$928,383.46	\$973,879.91	-\$45,496.45
		SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$17,563.53	\$17,563.53
		SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$17,563.53	\$17,563.53
	OFFICE OF RATES REIMBURSEMENT AND FINANCIAL ANALYSIS Total			\$1,956,743.06	\$2,140,962.81	-\$184,219.75
AGENCY MANAGEMENT PROGRAM Total				\$41,336,740.87	\$35,466,661.03	\$5,870,079.84

DC ACCESS SYSTEM	70152	DCAS - PROGRAM MANAGEMENT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$61.34	-\$61.34	
				CONTINUING FULL TIME	\$272,310.93	\$287,985.36	-\$15,674.43	
				CONTRACTUAL SERVICES - OTHER	\$505,589.73	\$434,154.50	\$71,435.23	
				FRINGE BENEFITS - CURR PERSONNEL	\$60,453.03	\$59,064.64	\$1,388.39	
			FEDERAL MEDICAID PAYMENTS Total		\$838,353.69	\$781,265.84	\$57,087.85	
			LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$58.58	-\$58.58	
				CONTINUING FULL TIME	\$278,680.78	\$276,104.16	\$2,576.62	
				CONTRACTUAL SERVICES - OTHER	\$572,056.15	\$506,298.70	\$65,757.45	
				FRINGE BENEFITS - CURR PERSONNEL	\$61,867.14	\$56,956.25	\$4,910.89	
				OTHER SERVICES & CHARGES	\$0.00	\$2,112.50	-\$2,112.50	
			LOCAL FUND Total		\$912,604.07	\$841,530.19	\$71,073.88	
			DCAS - PROGRAM MANAGEMENT DIVISION Total				\$1,750,957.76	\$1,622,796.03
	70153	PROJECT MANAGEMENT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$299.00	-\$299.00	
				CONTINUING FULL TIME	\$430,539.90	\$233,834.59	\$196,705.31	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$31,857.50	-\$31,857.50	
				CONTRACTUAL SERVICES - OTHER	\$1,467,656.06	\$955,509.45	\$512,146.61	
				ENERGY COMM & BLDG RENTALS	\$3,268.29	\$162.87	\$3,105.42	
				FRINGE BENEFITS - CURR PERSONNEL	\$90,179.85	\$74,937.19	\$15,242.66	
				OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00	
				OVERTIME PAY	\$0.00	\$0.00	\$0.00	
				PURCHASES EQUIPMENT & MACHINERY	\$69,300.00	\$0.00	\$69,300.00	
				SUPPLIES & MATERIALS	\$1,146.72	\$1,146.72	\$0.00	
			FEDERAL MEDICAID PAYMENTS Total		\$2,062,090.82	\$1,297,747.32	\$764,343.50	
			LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$285.49	-\$285.49	
				CONTINUING FULL TIME	\$440,611.02	\$224,168.64	\$216,442.38	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$30,648.96	-\$30,648.96	
				CONTRACTUAL SERVICES - OTHER	\$1,554,948.38	\$1,275,753.95	\$279,194.43	
				ENERGY COMM & BLDG RENTALS	\$3,344.74	\$166.68	\$3,178.06	
				FRINGE BENEFITS - CURR PERSONNEL	\$91,215.66	\$72,488.60	\$18,727.06	
				OTHER SERVICES & CHARGES	\$1,225.00	\$532.35	\$692.65	
				OVERTIME PAY	\$0.00	\$0.01	-\$0.01	
				PURCHASES EQUIPMENT & MACHINERY	\$4,435.32	\$0.00	\$4,435.32	
				SUPPLIES & MATERIALS	\$4,375.00	\$1,094.89	\$3,280.11	
			LOCAL FUND Total		\$2,100,155.12	\$1,605,139.57	\$495,015.55	
			PROJECT MANAGEMENT DIVISION Total				\$4,162,245.94	\$2,902,886.89
	70154	ORGANIZATIONAL CHANGE DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$48.34	-\$48.34	
				CONTINUING FULL TIME	\$361,215.00	\$320,981.88	\$40,233.12	
				CONTRACTUAL SERVICES - OTHER	\$3,294,432.07	\$2,929,087.90	\$365,344.17	
				ENERGY COMM & BLDG RENTALS	\$639,108.66	\$639,108.66	\$0.00	
				FRINGE BENEFITS - CURR PERSONNEL	\$80,189.74	\$75,126.41	\$5,063.33	
				PURCHASES EQUIPMENT & MACHINERY	\$128,250.00	\$52,432.93	\$75,817.07	
			FEDERAL MEDICAID PAYMENTS Total		\$4,503,195.47	\$4,016,786.12	\$486,409.35	
			LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$46.16	-\$46.16	
				CONTINUING FULL TIME	\$369,664.42	\$307,597.53	\$62,066.89	
				CONTRACTUAL SERVICES - OTHER	\$4,133,284.40	\$3,968,283.44	\$165,000.96	
				ENERGY COMM & BLDG RENTALS	\$654,058.57	\$700,291.36	-\$46,232.79	
				FRINGE BENEFITS - CURR PERSONNEL	\$82,065.50	\$72,611.02	\$9,454.48	
				PURCHASES EQUIPMENT & MACHINERY	\$82,506.85	\$70,206.28	\$12,300.57	
			LOCAL FUND Total		\$5,321,579.74	\$5,119,035.79	\$202,543.95	
			ORGANIZATIONAL CHANGE DIVISION Total				\$9,824,775.21	\$9,135,821.91
	70155	DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$58.53	-\$58.53	
				CONTINUING FULL TIME	\$463,641.42	\$436,122.32	\$27,519.10	
				CONTRACTUAL SERVICES - OTHER	\$20,440,633.55	\$19,538,129.27	\$902,504.28	
				FRINGE BENEFITS - CURR PERSONNEL	\$102,928.38	\$111,445.25	-\$8,516.87	
				OTHER SERVICES & CHARGES	\$1,128,129.98	\$1,125,193.01	\$2,936.97	
				PURCHASES EQUIPMENT & MACHINERY	\$5,989,364.20	\$5,690,897.99	\$298,466.21	
			FEDERAL MEDICAID PAYMENTS Total		\$28,124,697.53	\$26,901,846.37	\$1,222,851.16	
			LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$55.89	-\$55.89	
				CONTINUING FULL TIME	\$474,486.80	\$418,115.77	\$56,371.03	
				CONTRACTUAL SERVICES - OTHER	\$21,232,390.46	\$19,928,677.60	\$1,303,712.86	
				FRINGE BENEFITS - CURR PERSONNEL	\$105,336.06	\$107,674.04	-\$2,337.98	
				OTHER SERVICES & CHARGES	\$1,153,118.61	\$1,073,044.65	\$80,073.96	
				PURCHASES EQUIPMENT & MACHINERY	\$6,097,658.12	\$6,002,325.27	\$95,332.85	
				SUPPLIES & MATERIALS	-\$4,375.00	\$0.00	-\$4,375.00	
			LOCAL FUND Total		\$29,058,615.05	\$27,529,893.22	\$1,528,721.83	
			DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION Total				\$57,183,312.58	\$54,431,739.59
	70353	DCAS HHHS FUNCTIONAL DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$329,256.66	\$349,963.44	-\$20,706.78	
				FRINGE BENEFITS - CURR PERSONNEL	\$73,094.98	\$86,602.56	-\$13,507.58	
			FEDERAL MEDICAID PAYMENTS Total		\$402,351.64	\$436,566.00	-\$34,214.36	
			LOCAL FUND	CONTINUING FULL TIME	\$336,958.55	\$335,526.32	\$1,432.23	
				FRINGE BENEFITS - CURR PERSONNEL	\$74,804.80	\$83,652.56	-\$8,847.76	
			LOCAL FUND Total		\$411,763.35	\$419,178.88	-\$7,415.53	
			DCAS HHHS FUNCTIONAL DIVISION Total				\$814,114.99	\$855,744.88
DC ACCESS SYSTEM Total								
ELIGIBILITY & ENROLLMENT	70152	DCAS - PROGRAM MANAGEMENT DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00	
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$103.50	-\$103.50	
			FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$103.50	-\$103.50	
			LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00	
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$120.32	-\$120.32	
			LOCAL FUND Total		\$0.00	\$120.32	-\$120.32	
			DCAS - PROGRAM MANAGEMENT DIVISION Total				\$0.00	\$223.82
	70153	PROJECT MANAGEMENT DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00	
				ENERGY COMM & BLDG RENTALS	\$0.00	\$0.00	\$0.00	
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$156.24	-\$156.24	
			FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$156.24	-\$156.24	
			LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00	
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$240.66	-\$240.66	

70154	PROJECT MANAGEMENT DIVISION Total		LOCAL FUND Total		\$0.00	\$240.66	-\$240.66	
	ORGANIZATIONAL CHANGE DIVISION				\$0.00	\$396.90	-\$396.90	
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$39.76	\$39.76			
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	-\$39.76	\$39.76		
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00		
	ORGANIZATIONAL CHANGE DIVISION Total				\$0.00	-\$39.76	\$39.76	
	70155	DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION				\$0.00	\$0.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$476.13	\$476.13		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$55.81	\$55.81		
			OTHER SERVICES & CHARGES	\$0.00	-\$16,646.15	\$16,646.15		
			PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$40,455.78	-\$40,455.78		
			FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$23,277.69	-\$23,277.69	
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$487.27	\$487.27		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
			OTHER SERVICES & CHARGES	\$0.00	-\$183.13	\$183.13		
			PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$8,957.17	-\$8,957.17		
LOCAL FUND Total			\$0.00	\$8,286.77	-\$8,286.77			
DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION Total				\$0.00	\$31,564.46	-\$31,564.46		
70266		DIVISION OF ELIGIBILITY POLICY				\$0.00	\$0.00	\$0.00
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		CONTRACTUAL SERVICES - OTHER	\$0.00	\$2,245.14	-\$2,245.14			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$46.34	\$46.34			
	FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$2,198.80	-\$2,198.80			
	LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$2,245.14	\$2,245.14			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00			
	LOCAL FUND Total		\$0.00	-\$2,245.14	\$2,245.14			
	DIVISION OF ELIGIBILITY POLICY Total				\$0.00	-\$46.34	\$46.34	
70280	INFORMATION TECHNOLOGY DIVISION - HT0				\$0.00	\$4,002.84	-\$4,002.84	
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$4,002.84	-\$4,002.84		
	LOCAL FUND	CONTINUING FULL TIME	\$80,482.05	\$76,700.38	\$3,781.67			
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00			
		FRINGE BENEFITS - CURR PERSONNEL	\$18,188.95	\$22,286.87	-\$4,097.92			
	LOCAL FUND Total		\$98,671.00	\$98,987.25	-\$316.25			
INFORMATION TECHNOLOGY DIVISION - HT0 Total				\$98,671.00	\$102,990.09	-\$4,319.09		
ELIGIBILITY & ENROLLMENT Total				\$98,671.00	\$135,089.17	-\$36,418.17		
HEALTH CARE ANALYTICS	70268 HIT/HIE PROJECT MANAGEMENT DIVISION				\$0.00	\$0.00	\$0.00	
	DEDICATED TAXES	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00			
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$863.99	\$863.99			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00			
		DEDICATED TAXES Total		\$0.00	-\$863.99	\$863.99		
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
	CONTINUING FULL TIME - OTHERS		\$0.00	\$0.00	\$0.00			
	CONTRACTUAL SERVICES - OTHER		\$0.00	\$863.99	-\$863.99			
	FRINGE BENEFITS - CURR PERSONNEL		\$0.00	-\$16.43	\$16.43			
	FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$847.56	-\$847.56			
	HIT/HIE PROJECT MANAGEMENT DIVISION Total				\$0.00	-\$16.43	\$16.43	
	70269	HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES DIVISION				\$0.00	\$0.00	\$0.00
		DEDICATED TAXES	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
			OTHER SERVICES & CHARGES	\$0.00	-\$21,350.76	\$21,350.76		
		DEDICATED TAXES Total		\$0.00	-\$21,350.76	\$21,350.76		
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$2,867.85	-\$2,867.85		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
			GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00		
OTHER SERVICES & CHARGES			\$0.00	\$21,350.76	-\$21,350.76			
FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$24,218.61	-\$24,218.61				
LOCAL FUND		CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$2,867.85	\$2,867.85			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00			
		GOVERNMENT SUBSIDIES & GRANTS	\$0.00	-\$66,750.15	\$66,750.15			
LOCAL FUND Total		\$0.00	-\$69,618.00	\$69,618.00				
HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES DIVISION Total				\$0.00	-\$66,750.15	\$66,750.15		
70278	SUPPORT SERVICES DIVISION - HT0				\$0.00	-\$363.46	\$363.46	
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00			
		CONTRACTUAL SERVICES - OTHER	\$0.00	\$12,588.49	-\$12,588.49			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$27.62	\$27.62			
		OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00			
	FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$12,197.41	-\$12,197.41			
	LOCAL FUND	CONTINUING FULL TIME	\$0.00	-\$444.24	\$444.24			
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00			
		OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00			
	LOCAL FUND Total		\$0.00	-\$444.24	\$444.24			
	SPECIAL PURPOSE REVENUE FUNDS		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$12,588.49	\$12,588.49		
	SPECIAL PURPOSE REVENUE FUNDS Total				\$0.00	-\$12,588.49	\$12,588.49	
SUPPORT SERVICES DIVISION - HT0 Total				\$0.00	-\$835.32	\$835.32		
70488	ANALYTICS AND RESEARCH				\$0.00	\$0.00	\$0.00	
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00			
		CONTRACTUAL SERVICES - OTHER	\$0.00	\$4,351.20	-\$4,351.20			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$29.80	\$29.80			
	FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$4,321.40	-\$4,321.40			
	LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00			
		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00			
		CONTRACTUAL SERVICES - OTHER	\$0.00	-\$4,351.19	\$4,351.19			
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00			
	LOCAL FUND Total		\$0.00	-\$4,351.19	\$4,351.19			
ANALYTICS AND RESEARCH Total				\$0.00	-\$29.79	\$29.79		

HEALTH CARE ANALYTICS Total				\$0.00	-\$67,631.69	\$67,631.69
HEALTH CARE DELIVERY MANAGE	70159	HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL OTHER SERVICES & CHARGES PURCHASES EQUIPMENT & MACHINERY SUPPLIES & MATERIALS	\$0.00 \$436,884.22 \$0.00 \$105,415.88 \$2,969.32 \$0.00 \$664.69	\$65.09 \$471,583.07 \$9,813.59 \$108,286.78 \$2,969.32 \$0.00 \$664.69
						-\$65.09 -\$34,698.85 -\$9,813.59 -\$2,870.90 \$0.00 \$0.00 \$0.00
			FEDERAL MEDICAID PAYMENTS Total		\$545,934.11	\$593,382.54
			LOCAL FUND	ADDITIONAL GROSS PAY CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL OTHER SERVICES & CHARGES PURCHASES EQUIPMENT & MACHINERY SUPPLIES & MATERIALS	\$0.00 \$639,411.28 \$0.00 \$85,287.96 \$3,629.13 \$0.00 \$812.40	\$79.56 \$499,271.76 -\$9,813.59 \$133,370.39 \$3,629.13 \$0.00 \$0.00
			LOCAL FUND Total		\$729,140.77	\$627,349.61
		HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION Total			\$1,275,074.88	\$1,220,732.15
	70160	DIVISION OF MANAGED CARE	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL	\$387,204.61 \$3,562,694.64 \$85,621.80	\$358,032.52 \$3,564,574.95 \$78,381.62
			FEDERAL MEDICAID PAYMENTS Total		\$4,055,521.05	\$4,000,989.09
			LOCAL FUND	CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL	\$458,049.46 \$4,241,308.57 \$52,350.95	\$381,585.78 \$4,169,065.04 \$96,475.92
			LOCAL FUND Total		\$4,751,708.98	\$4,647,126.74
			SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$81,699.87
			SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$81,699.87
		DIVISION OF MANAGED CARE Total			\$8,807,230.03	\$8,566,415.96
	70161	DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES	FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$6,853,560.88	\$5,241,849.31
			FEDERAL MEDICAID PAYMENTS Total		\$6,853,560.88	\$5,241,849.31
			LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$2,711,959.50	\$2,606,059.20
			LOCAL FUND Total		\$2,711,959.50	\$2,606,059.20
			SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$7,266.83
			SPECIAL PURPOSE REVENUE FUNDS Total		\$0.00	-\$7,266.83
		DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES Total			\$9,565,520.73	\$7,840,641.68
	70162	DIVISION OF QUALITY AND HEALTH OUTCOMES	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL	\$0.00 \$137,960.11 \$1,401,778.50 \$88,239.73	\$246.37 \$150,141.26 \$1,403,899.39 \$31,824.21
			FEDERAL MEDICAID PAYMENTS Total		\$1,627,978.34	\$1,586,111.23
			LOCAL FUND	ADDITIONAL GROSS PAY CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL	\$0.00 \$461,997.50 \$467,259.50 \$9,389.21	\$301.13 \$156,437.36 \$465,137.61 \$39,145.05
			LOCAL FUND Total		\$938,646.21	\$661,021.15
		DIVISION OF QUALITY AND HEALTH OUTCOMES Total			\$2,566,624.55	\$2,247,132.38
	70163	DIVISION OF CHILDREN'S HEALTH SERVICES	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL OTHER SERVICES & CHARGES SUPPLIES & MATERIALS	\$215,773.45 \$193,468.42 \$47,901.70 \$69,095.87 \$10,000.00	\$237,770.17 \$120,539.60 \$47,421.34 \$28,284.74 \$6,922.50
			FEDERAL MEDICAID PAYMENTS Total		\$536,239.44	\$440,938.35
			LOCAL FUND	CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL OTHER SERVICES & CHARGES	\$263,723.11 \$192,754.07 \$58,546.53 \$20,378.92	\$252,588.45 \$85,038.75 \$58,374.74 \$0.00
			LOCAL FUND Total		\$515,023.71	\$416,380.86
		DIVISION OF CHILDREN'S HEALTH SERVICES Total			\$1,051,263.15	\$857,319.21
HEALTH CARE DELIVERY MANAGEMENT Total					\$23,265,713.34	\$20,732,241.38
HEALTH CARE OPERATIONS	70260	HEALTH CARE OPERATIONS SUPPORT OFFICE	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL OTHER SERVICES & CHARGES PURCHASES EQUIPMENT & MACHINERY SUPPLIES & MATERIALS	\$164,476.42 \$0.00 \$36,513.77 \$0.00 \$0.00 \$585.00	\$187,259.09 \$3,770.02 \$33,682.43 \$0.00 \$0.00 \$583.39
			FEDERAL MEDICAID PAYMENTS Total		\$201,575.19	\$225,294.93
			LOCAL FUND	CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL OTHER SERVICES & CHARGES PURCHASES EQUIPMENT & MACHINERY SUPPLIES & MATERIALS	\$201,026.73 \$0.00 \$44,627.94 \$0.00 \$0.00 \$715.00	\$197,864.52 -\$3,770.02 \$41,279.69 \$0.00 \$0.00 \$713.05
			LOCAL FUND Total		\$246,369.67	\$236,087.24
		HEALTH CARE OPERATIONS SUPPORT OFFICE Total			\$447,944.86	\$461,382.17
	70261	DIVISION OF CLAIMS MANAGEMENT	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL	\$0.00 \$732,685.66 \$36,465,939.30 \$162,754.40	\$195.23 \$797,335.37 \$33,828,532.75 \$178,129.94
			FEDERAL MEDICAID PAYMENTS Total		\$37,361,379.36	\$34,804,193.29
			LOCAL FUND	CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL	\$433,920.07 \$12,959,783.36 \$96,450.26	\$475,567.70 \$12,643,263.70 \$132,606.41
			LOCAL FUND Total		\$13,490,153.69	\$13,251,437.81
			SPECIAL PURPOSE REVENUE FUNDS	ADDITIONAL GROSS PAY CONTINUING FULL TIME CONTRACTUAL SERVICES - OTHER FRINGE BENEFITS - CURR PERSONNEL	\$0.00 \$253,930.29 \$472,211.37 \$22,128.95	\$238.62 \$223,635.94 \$472,211.33 \$52,184.68
			SPECIAL PURPOSE REVENUE FUNDS Total		\$748,270.61	\$748,270.57
		DIVISION OF CLAIMS MANAGEMENT Total			\$51,599,803.66	\$48,803,901.67
	70262	DIVISION OF PUBLIC AND PRIVATE PROVIDER SERVICES	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$304.61
						-\$304.61

					CONTINUING FULL TIME	\$491,225.94	\$473,806.05	\$17,419.89
					CONTRACTUAL SERVICES - OTHER	\$913,232.54	\$918,526.02	-\$5,293.48
					FRINGE BENEFITS - CURR PERSONNEL	\$109,052.16	\$100,512.48	\$8,539.68
					FEDERAL MEDICAID PAYMENTS Total	\$1,513,510.64	\$1,493,149.16	\$20,361.48
				LOCAL FUND				
					ADDITIONAL GROSS PAY	\$0.00	\$372.31	-\$372.31
					CONTINUING FULL TIME	\$594,689.46	\$498,266.52	\$96,422.94
					CONTRACTUAL SERVICES - OTHER	\$1,116,173.10	\$1,101,585.65	\$14,587.45
					FRINGE BENEFITS - CURR PERSONNEL	\$109,584.58	\$123,705.43	-\$14,120.85
				LOCAL FUND Total		\$1,820,447.14	\$1,723,929.91	\$96,517.23
						\$3,333,957.78	\$3,217,079.07	\$116,878.71
HEALTH CARE OPERATIONS Total						\$55,381,706.30	\$52,482,362.91	\$2,899,343.39
HEALTH CARE POLICY AND RESEAR	70263	HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVISION	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00	\$0.00
				FRINGE BENEFITS - CURR PERSONNEL	\$20,174.51	\$0.00	\$20,174.51	
				FEDERAL GRANT FUND - FPR Total		\$20,174.51	\$0.00	\$20,174.51
			FEDERAL MEDICAID PAYMENTS					
				CONTINUING FULL TIME	\$170,891.81	\$182,860.47	-\$11,968.66	
				CONTRACTUAL SERVICES - OTHER	\$122,323.02	\$115,246.11	\$7,076.91	
				FRINGE BENEFITS - CURR PERSONNEL	\$37,937.99	\$37,553.69	\$384.30	
				OTHER SERVICES & CHARGES	\$11,437.49	\$6,372.80	\$5,064.69	
				PURCHASES EQUIPMENT & MACHINERY	\$3,262.78	\$557.55	\$2,705.23	
				SUPPLIES & MATERIALS	\$468.00	\$0.00	\$468.00	
				FEDERAL MEDICAID PAYMENTS Total		\$346,321.09	\$342,590.62	\$3,730.47
			LOCAL FUND					
				CONTINUING FULL TIME	\$208,867.77	\$194,036.20	\$14,831.57	
				CONTRACTUAL SERVICES - OTHER	\$149,505.90	\$111,045.94	\$38,459.96	
				FRINGE BENEFITS - CURR PERSONNEL	\$46,368.65	\$46,149.76	\$218.89	
				OTHER SERVICES & CHARGES	\$8,897.35	\$7,788.99	\$1,108.36	
				PURCHASES EQUIPMENT & MACHINERY	\$3,987.84	\$0.00	\$3,987.84	
				SUPPLIES & MATERIALS	\$572.00	\$0.00	\$572.00	
			LOCAL FUND Total			\$418,199.51	\$359,020.89	\$59,178.62
						\$784,695.11	\$701,611.51	\$83,083.60
			HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVISION Total					
	70264	DIVISION OF REGULATIONS & POLICY MANAGEMENT	FEDERAL MEDICAID PAYMENTS					
				ADDITIONAL GROSS PAY	\$0.00	\$348.39	-\$348.39	
				CONTINUING FULL TIME	\$310,911.84	\$240,933.16	\$69,978.68	
				CONTRACTUAL SERVICES - OTHERS	\$58,818.84	\$42,526.54	\$16,292.30	
				CONTRACTUAL SERVICES - OTHER	\$0.00	\$6,383.63	-\$6,383.63	
				FRINGE BENEFITS - CURR PERSONNEL	\$82,080.20	\$69,205.42	\$12,874.78	
				FEDERAL MEDICAID PAYMENTS Total		\$451,810.88	\$359,397.14	\$92,413.74
			LOCAL FUND					
				ADDITIONAL GROSS PAY	\$0.00	\$425.82	-\$425.82	
				CONTINUING FULL TIME	\$375,908.49	\$248,876.97	\$127,031.52	
				CONTINUING FULL TIME - OTHERS	\$71,889.69	\$51,977.20	\$19,912.49	
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$6,383.63	\$6,383.63	
				FRINGE BENEFITS - CURR PERSONNEL	\$82,386.20	\$85,294.88	-\$2,908.68	
			LOCAL FUND Total			\$530,184.38	\$380,191.24	\$149,993.14
						\$981,995.26	\$739,588.38	\$242,406.88
			DIVISION OF REGULATIONS & POLICY MANAGEMENT Total					
	70266	DIVISION OF ELIGIBILITY POLICY	FEDERAL MEDICAID PAYMENTS					
				ADDITIONAL GROSS PAY	\$0.00	\$190.25	-\$190.25	
				CONTINUING FULL TIME	\$357,885.52	\$312,671.16	\$45,214.36	
				CONTRACTUAL SERVICES - OTHER	\$525,937.05	\$324,722.57	\$201,214.48	
				FRINGE BENEFITS - CURR PERSONNEL	\$57,850.58	\$80,491.34	-\$22,640.76	
				FEDERAL MEDICAID PAYMENTS Total		\$941,673.15	\$718,075.32	\$223,597.83
			LOCAL FUND					
				ADDITIONAL GROSS PAY	\$0.00	\$232.53	-\$232.53	
				CONTINUING FULL TIME	\$433,051.99	\$329,542.40	\$103,509.59	
				CONTRACTUAL SERVICES - OTHER	\$615,312.41	\$258,543.83	\$356,768.58	
				FRINGE BENEFITS - CURR PERSONNEL	\$51,805.16	\$99,204.27	-\$47,399.11	
			LOCAL FUND Total			\$1,100,169.56	\$687,523.03	\$412,646.53
						\$2,041,842.71	\$1,405,598.35	\$636,244.36
			DIVISION OF ELIGIBILITY POLICY Total					
	70534	ELIGIBILITY DETERMINATION	FEDERAL MEDICAID PAYMENTS					
				ADDITIONAL GROSS PAY	\$0.00	\$11,012.82	-\$11,012.82	
				CONTINUING FULL TIME	\$661,824.45	\$751,502.06	-\$89,677.61	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$27,822.73	-\$27,822.73	
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$200,955.47	-\$200,955.47	
				OVERTIME PAY	\$0.00	\$27,574.85	-\$27,574.85	
				FEDERAL MEDICAID PAYMENTS Total		\$661,824.45	\$1,018,867.93	-\$357,043.48
			LOCAL FUND					
				ADDITIONAL GROSS PAY	\$0.00	\$13,460.11	-\$13,460.11	
				CONTINUING FULL TIME	\$698,304.57	\$918,502.51	-\$220,197.94	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$34,005.57	-\$34,005.57	
				FRINGE BENEFITS - CURR PERSONNEL	\$194,021.89	\$247,450.11	-\$53,428.22	
				OVERTIME PAY	\$0.00	\$33,702.91	-\$33,702.91	
			LOCAL FUND Total			\$892,326.46	\$1,247,121.21	-\$354,794.75
						\$1,554,150.91	\$2,265,989.14	-\$711,838.23
HEALTH CARE POLICY AND RESEARCH Total								
HEALTH CARE REFORM AND INNOV	70267	AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION	DEDICATED TAXES					
				ADDITIONAL GROSS PAY	\$0.00	\$1,015.00	-\$1,015.00	
				CONTINUING FULL TIME	\$151,726.97	\$151,726.97	\$0.00	
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$4,291.09	\$4,291.09	
				FRINGE BENEFITS - CURR PERSONNEL	\$25,450.28	\$38,629.75	-\$13,179.47	
				OVERTIME PAY	\$0.00	\$551.58	-\$551.58	
				DEDICATED TAXES Total		\$177,177.25	\$187,632.21	-\$10,454.96
			FEDERAL GRANT FUND - FPR					
				CONTINUING FULL TIME - OTHERS	\$25,000.00	\$0.00	\$25,000.00	
				CONTRACTUAL SERVICES - OTHER	\$98,560.00	\$98,560.00	\$0.00	
				FRINGE BENEFITS - CURR PERSONNEL	\$60,225.10	\$0.00	\$60,225.10	
				GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00	
				PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00	
				FEDERAL GRANT FUND - FPR Total		\$183,785.10	\$98,560.00	\$85,225.10
			FEDERAL MEDICAID PAYMENTS					
				ADDITIONAL GROSS PAY	\$0.00	\$830.47	-\$830.47	
				CONTINUING FULL TIME	\$181,256.07	\$141,309.42	\$39,946.65	
				CONTRACTUAL SERVICES - OTHER	\$946,732.05	\$915,293.76	\$31,438.29	
				FRINGE BENEFITS - CURR PERSONNEL	\$40,238.85	\$31,421.22	\$8,817.63	
				GOVERNMENT SUBSIDIES & GRANTS	\$307,660.28	\$0.00	\$307,660.28	
				OVERTIME PAY	\$0.00	\$451.29	-\$451.29	
				FEDERAL MEDICAID PAYMENTS Total		\$1,475,887.25	\$1,089,306.16	\$386,581.09
			LOCAL FUND					
				CONTINUING FULL TIME	\$0.00	-\$2,010.45	\$2,010.45	
				CONTRACTUAL SERVICES - OTHER	\$1,157,116.95	\$990,535.51	\$166,581.44	
				GOVERNMENT SUBSIDIES & GRANTS	\$2,506,547.37	\$1,162,500.00	\$1,344,047.37	
			LOCAL FUND Total			\$3,663,664.32	\$2,151,025.06	\$1,512,639.26
						\$5,500,513.92	\$3,526,523.43	\$1,973,990.49
			AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION Total					

70268	HIT/HIE PROJECT MANAGEMENT DIVISION			DEDICATED TAXES	ADDITIONAL GROSS PAY	\$0.00	\$583.29	-\$583.29				
				CONTINUING FULL TIME	\$127,464.00	\$127,464.00	\$0.00					
				CONTINUING FULL TIME - OTHERS	\$74,063.55	\$74,266.97	-\$203.42					
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$2,817.31	\$2,817.31					
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$41,186.53	-\$41,186.53					
				DEDICATED TAXES Total		\$201,527.55	\$240,683.48	-\$39,155.93				
				FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$1,749.85	-\$1,749.85				
				CONTINUING FULL TIME	\$336,727.28	\$419,010.01	-\$82,282.73					
				CONTINUING FULL TIME - OTHERS	\$101,459.70	\$98,080.34	\$3,379.36					
				CONTRACTUAL SERVICES - OTHER	\$103,118.40	\$105,341.71	-\$2,223.31					
				FRINGE BENEFITS - CURR PERSONNEL	\$97,277.50	\$111,351.08	-\$14,073.58					
				GOVERNMENT SUBSIDIES & GRANTS	\$4,485,432.00	\$4,485,431.97	\$0.03					
				PURCHASES EQUIPMENT & MACHINERY	\$2,250.00	\$0.00	\$2,250.00					
				SUPPLIES & MATERIALS	\$1,980.00	\$0.00	\$1,980.00					
				FEDERAL MEDICAID PAYMENTS Total		\$5,128,244.88	\$5,220,964.96	-\$92,720.08				
				LOCAL FUND	CONTINUING FULL TIME	\$14,212.90	\$28,041.78	-\$13,828.88				
				CONTINUING FULL TIME - OTHERS	\$49,942.75	\$18,327.41	\$31,615.34					
				CONTRACTUAL SERVICES - OTHER	\$12,507.60	\$12,441.60	\$66.00					
				FRINGE BENEFITS - CURR PERSONNEL	\$14,242.55	\$13,283.74	\$958.81					
				GOVERNMENT SUBSIDIES & GRANTS	\$2,228,189.30	\$1,885,163.37	\$343,025.93					
PURCHASES EQUIPMENT & MACHINERY	\$2,750.00	\$0.00	\$2,750.00									
SUPPLIES & MATERIALS	\$220.00	\$0.00	\$220.00									
LOCAL FUND Total		\$2,322,065.10	\$1,957,257.90	\$364,807.20								
HIT/HIE PROJECT MANAGEMENT DIVISION Total						\$7,651,837.53	\$7,418,906.34	\$232,931.19				
70269	HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES DIVISION			DEDICATED TAXES	CONTINUING FULL TIME	\$55,623.70	\$42,292.87	\$13,330.83				
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$2,407.71	\$2,407.71					
				FRINGE BENEFITS - CURR PERSONNEL	\$12,348.46	\$6,549.94	\$5,798.52					
				OTHER SERVICES & CHARGES	\$1,254.09	\$1,254.09	\$0.00					
				PURCHASES EQUIPMENT & MACHINERY	\$2,479.46	\$0.00	\$2,479.46					
				SUPPLIES & MATERIALS	\$2,090.00	\$0.00	\$2,090.00					
				DEDICATED TAXES Total		\$73,795.71	\$47,689.19	\$26,106.52				
				FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$157,979.70	\$158,124.52	-\$144.82				
				CONTRACTUAL SERVICES - OTHER	\$0.00	\$2,785.78	-\$2,785.78					
				FRINGE BENEFITS - CURR PERSONNEL	\$35,071.50	\$20,567.61	\$14,503.89					
				OTHER SERVICES & CHARGES	\$1,026.06	\$1,026.06	\$0.00					
				PURCHASES EQUIPMENT & MACHINERY	\$2,028.65	\$0.00	\$2,028.65					
				SUPPLIES & MATERIALS	\$1,710.00	\$0.00	\$1,710.00					
				FEDERAL MEDICAID PAYMENTS Total		\$197,815.91	\$182,503.97	\$15,311.94				
				LOCAL FUND	CONTINUING FULL TIME	\$137,462.60	\$131,488.11	\$5,974.49				
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$378.07	\$378.07					
				FRINGE BENEFITS - CURR PERSONNEL	\$30,516.70	\$19,042.37	\$11,474.33					
				LOCAL FUND Total		\$167,979.30	\$150,152.41	\$17,826.89				
				HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES DIVISION Total						\$439,590.92	\$380,345.57	\$59,245.35
				HEALTH CARE REFORM AND INNOVATION Total								
LONG TERM CARE PROGRAM		70270	LONG TERM CARE SUPPORT SERVICES DIVISION									
FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME								\$257,489.99	\$152,482.88	\$105,007.11	
CONTINUING FULL TIME - OTHERS	\$45,372.15								\$14,421.24	\$30,950.91		
CONTRACTUAL SERVICES - OTHER	\$0.00								\$4,024.04	-\$4,024.04		
FRINGE BENEFITS - CURR PERSONNEL	\$67,235.40								\$29,723.88	\$37,511.52		
OTHER SERVICES & CHARGES	\$7,131.60								\$315.00	\$6,816.60		
OVERTIME PAY	\$0.00								\$1,229.34	-\$1,229.34		
PURCHASES EQUIPMENT & MACHINERY	\$7,050.41								\$0.00	\$7,050.41		
SUPPLIES & MATERIALS	\$741.00								\$143.60	\$597.40		
FEDERAL MEDICAID PAYMENTS Total									\$385,020.55	\$202,339.98	\$182,680.57	
LOCAL FUND	CONTINUING FULL TIME								\$304,672.69	\$159,465.74	\$145,206.95	
CONTINUING FULL TIME - OTHERS	\$51,359.99								\$17,626.07	\$33,733.92		
CONTRACTUAL SERVICES - OTHER	\$0.00								-\$4,024.04	\$4,024.04		
FRINGE BENEFITS - CURR PERSONNEL	\$21,726.98								\$36,530.09	-\$14,803.11		
OTHER SERVICES & CHARGES	\$8,702.61								\$385.00	\$8,317.61		
OVERTIME PAY	\$0.00								\$1,502.54	-\$1,502.54		
PURCHASES EQUIPMENT & MACHINERY	\$6,137.33								\$0.00	\$6,137.33		
SUPPLIES & MATERIALS	\$905.66								\$175.50	\$730.16		
LOCAL FUND Total									\$393,505.26	\$211,660.90	\$181,844.36	
SPECIAL PURPOSE REVENUE FUNDS	CONTINUING FULL TIME	\$0.00	-\$4,487.01	\$4,487.01								
SPECIAL PURPOSE REVENUE FUNDS Total						\$0.00	-\$4,487.01	\$4,487.01				
LONG TERM CARE SUPPORT SERVICES DIVISION Total						\$778,525.81	\$409,513.87	\$369,011.94				
70271	LONG TERM CARE OVERSIGHT DIVISION			FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00				
				CONTINUING FULL TIME - OTHERS	\$181,575.68	\$406,286.26	-\$224,710.58					
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$76,348.93	-\$76,348.93					
				FEDERAL GRANT FUND - FPR Total		\$181,575.68	\$482,635.19	-\$301,059.51				
				FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$1,125.00	-\$1,125.00				
				CONTINUING FULL TIME	\$691,076.10	\$781,800.98	-\$90,724.88					
				CONTRACTUAL SERVICES - OTHER	\$0.00	\$10,729.96	-\$10,729.96					
				FRINGE BENEFITS - CURR PERSONNEL	\$153,541.63	\$161,857.73	-\$8,316.10					
				FEDERAL MEDICAID PAYMENTS Total		\$844,617.73	\$955,513.67	-\$110,895.94				
				LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$375.00	-\$375.00				
				CONTINUING FULL TIME	\$651,659.86	\$631,749.52	\$19,910.34					
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$10,729.96	\$10,729.96					
				FRINGE BENEFITS - CURR PERSONNEL	\$122,382.03	\$152,831.38	-\$30,449.35					
				LOCAL FUND Total		\$774,041.89	\$774,225.94	-\$184.05				
				LONG TERM CARE OVERSIGHT DIVISION Total						\$1,800,235.30	\$2,212,374.80	-\$412,139.50
				70272	LONG TERM CARE OPERATIONS DIVISION			FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$229,594.56	\$0.00	\$229,594.56
								CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00	
								FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00	
								GOVERNMENT SUBSIDIES & GRANTS	\$352,135.87	\$352,135.88	-\$0.01	
								OTHER SERVICES & CHARGES	\$1,785.00	\$2,143.06	-\$358.06	
PURCHASES EQUIPMENT & MACHINERY	\$327,280.80	\$327,280.80	\$0.00									
FEDERAL GRANT FUND - FPR Total		\$910,796.23	\$681,559.74					\$229,236.49				
FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$1,426.99					-\$1,426.99				
CONTINUING FULL TIME	\$749,076.08	\$783,424.08	-\$34,348.00									
CONTRACTUAL SERVICES - OTHER	\$1,970,666.11	\$2,167,797.54	-\$197,131.43									
FRINGE BENEFITS - CURR PERSONNEL	\$170,899.54	\$176,053.94	-\$5,154.40									

				OVERTIME PAY	\$0.00	\$390.67	-\$390.67
				FEDERAL MEDICAID PAYMENTS Total	\$2,890,641.73	\$3,129,093.22	-\$238,451.49
			LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$1,744.07	-\$1,744.07
				CONTINUING FULL TIME	\$908,637.05	\$830,221.09	\$78,415.96
				CONTRACTUAL SERVICES - OTHER	\$4,195,198.04	\$2,297,933.36	\$1,897,264.68
				FRINGE BENEFITS - CURR PERSONNEL	\$177,647.98	\$216,749.41	-\$39,101.43
				OVERTIME PAY	\$0.00	\$477.48	-\$477.48
				LOCAL FUND Total	\$5,281,483.07	\$3,347,125.41	\$1,934,357.66
				LONG TERM CARE OPERATIONS DIVISION Total	\$9,082,921.03	\$7,157,778.37	\$1,925,142.66
	70273	INTAKE AND ASSESSMENT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$3,348.74	-\$3,348.74
				CONTINUING FULL TIME	\$516,437.53	\$392,943.94	\$123,493.59
				CONTRACTUAL SERVICES - OTHER	\$3,540,830.41	\$3,757,063.91	-\$216,233.50
				FRINGE BENEFITS - CURR PERSONNEL	\$114,649.13	\$115,183.46	-\$534.33
				OVERTIME PAY	\$0.00	\$90.84	-\$90.84
				FEDERAL MEDICAID PAYMENTS Total	\$4,171,917.07	\$4,268,630.89	-\$96,713.82
			LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$2,092.90	-\$2,092.90
				CONTINUING FULL TIME	\$286,781.86	\$214,949.12	\$71,832.74
				CONTRACTUAL SERVICES - OTHER	\$4,836,435.80	\$4,099,928.05	\$736,507.75
				FRINGE BENEFITS - CURR PERSONNEL	\$17,392.05	\$61,406.41	-\$44,014.36
				OVERTIME PAY	\$0.00	\$30.28	-\$30.28
				LOCAL FUND Total	\$5,140,609.71	\$4,378,406.76	\$762,202.95
				INTAKE AND ASSESSMENT DIVISION Total	\$9,312,526.78	\$8,647,037.65	\$665,489.13
				LONG TERM CARE PROGRAM Total	\$20,974,208.92	\$18,426,704.69	\$2,547,504.23
MMIS SYSTEM AND INFRASTRUCTURE	70260	HEALTH CARE OPERATIONS SUPPORT OFFICE	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
				CONTRACTUAL SERVICES - OTHER	\$0.00	\$1,164.54	-\$1,164.54
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$7.03	\$7.03
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$1,157.51	-\$1,157.51
			LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$1,164.53	\$1,164.53
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
				OTHER SERVICES & CHARGES	\$0.00	\$0.00	\$0.00
				LOCAL FUND Total	\$0.00	-\$1,164.53	\$1,164.53
				HEALTH CARE OPERATIONS SUPPORT OFFICE Total	\$0.00	-\$7.02	\$7.02
	70261	DIVISION OF CLAIMS MANAGEMENT	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
				CONTRACTUAL SERVICES - OTHER	\$0.00	\$8,444.56	-\$8,444.56
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$76.30	\$76.30
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$8,368.26	-\$8,368.26
			LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$12,146.81	\$12,146.81
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
				LOCAL FUND Total	\$0.00	-\$12,146.81	\$12,146.81
			SPECIAL PURPOSE REVENUE FUNDS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
				SPECIAL PURPOSE REVENUE FUNDS Total	\$0.00	\$0.00	\$0.00
				DIVISION OF CLAIMS MANAGEMENT Total	\$0.00	-\$3,778.55	\$3,778.55
MMIS SYSTEM AND INFRASTRUCTURE Total					\$0.00	-\$3,785.57	\$3,785.57
NO PROGRAM	0	NO COST CENTER	LOCAL FUND	P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$4,995.00	-\$4,995.00
				LOCAL FUND Total	\$0.00	\$4,995.00	-\$4,995.00
				NO COST CENTER Total	\$0.00	\$4,995.00	-\$4,995.00
	70155	DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION	LOCAL FUND	PURCHASES EQUIPMENT & MACHINERY	\$0.00	-\$15,672.57	\$15,672.57
				LOCAL FUND Total	\$0.00	-\$15,672.57	\$15,672.57
				DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION Total	\$0.00	-\$15,672.57	\$15,672.57
	70163	DIVISION OF CHILDREN'S HEALTH SERVICES	FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$1,223.88	\$1,223.88
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	-\$1,223.88	\$1,223.88
			LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$1,495.86	\$1,495.86
				LOCAL FUND Total	\$0.00	-\$1,495.86	\$1,495.86
				DIVISION OF CHILDREN'S HEALTH SERVICES Total	\$0.00	-\$2,719.74	\$2,719.74
	70244	DC PUBLIC SCHOOLS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	-\$13,972,129.00	\$13,972,129.00
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	-\$13,972,129.00	\$13,972,129.00
				DC PUBLIC SCHOOLS Total	\$0.00	-\$13,972,129.00	\$13,972,129.00
	70248	OSSE-CHILDREN W/SPL NEEDS TRNSPT	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	-\$1,223,186.00	\$1,223,186.00
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	-\$1,223,186.00	\$1,223,186.00
				OSSE-CHILDREN W/SPL NEEDS TRNSPT Total	\$0.00	-\$1,223,186.00	\$1,223,186.00
	70261	DIVISION OF CLAIMS MANAGEMENT	LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	\$657,942.00	-\$657,942.00
				LOCAL FUND Total	\$0.00	\$657,942.00	-\$657,942.00
				DIVISION OF CLAIMS MANAGEMENT Total	\$0.00	\$657,942.00	-\$657,942.00
	70279	HUMAN RESOURCES DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	OTHER SERVICES & CHARGES	\$0.00	-\$779.05	\$779.05
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	-\$779.05	\$779.05
			LOCAL FUND	OTHER SERVICES & CHARGES	\$0.00	-\$952.17	\$952.17
				LOCAL FUND Total	\$0.00	-\$952.17	\$952.17
				HUMAN RESOURCES DIVISION - HT0 Total	\$0.00	-\$1,731.22	\$1,731.22
NO PROGRAM Total					\$0.00	-\$14,552,501.53	\$14,552,501.53
PROGRAM OVERSIGHT	70158	PROGRAM INTEGRITY SUPPORT DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	-\$3,590.32	\$3,590.32
				CONTRACTUAL SERVICES - OTHER	\$0.00	\$7,832.82	-\$7,832.82
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$148.35	\$148.35
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$4,094.15	-\$4,094.15
			LOCAL FUND	CONTINUING FULL TIME	\$0.00	-\$4,388.18	\$4,388.18
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$270.76	\$270.76
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
				LOCAL FUND Total	\$0.00	-\$4,658.94	\$4,658.94
			SPECIAL PURPOSE REVENUE FUNDS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$7,562.06	\$7,562.06
				SPECIAL PURPOSE REVENUE FUNDS Total	\$0.00	-\$7,562.06	\$7,562.06
				PROGRAM INTEGRITY SUPPORT DIVISION Total	\$0.00	-\$8,126.85	\$8,126.85
	70159	HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
				CONTRACTUAL SERVICES - OTHER	\$0.00	\$2,625.43	-\$2,625.43
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$37.18	\$37.18
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$2,588.25	-\$2,588.25
			LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
				CONTRACTUAL SERVICES - OTHER	\$0.00	-\$2,625.43	\$2,625.43
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
				LOCAL FUND Total	\$0.00	-\$2,625.43	\$2,625.43

HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION Total				\$0.00	-\$37.18	\$37.18		
70160	DIVISION OF MANAGED CARE	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00		
			CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$67,095.83	-\$67,095.83		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$37.86	\$37.86		
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$67,057.97	-\$67,057.97		
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00		
			CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$69,595.12	\$69,595.12		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
		LOCAL FUND Total		\$0.00	-\$69,595.12	\$69,595.12		
DIVISION OF MANAGED CARE Total				\$0.00	-\$2,537.15	\$2,537.15		
70161	DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$768,591.95	\$768,591.95		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$64.48	\$64.48		
			FEDERAL MEDICAID PAYMENTS Total		\$0.00	-\$768,656.43	\$768,656.43	
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$267,589.42	\$267,589.42		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
			LOCAL FUND Total		\$0.00	-\$267,589.42	\$267,589.42	
		DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES Total				\$0.00	-\$1,036,245.85	\$1,036,245.85
		70162	DIVISION OF QUALITY AND HEALTH OUTCOMES	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
CONTRACTUAL SERVICES - OTHER	\$0.00				\$436.75	-\$436.75		
FRINGE BENEFITS - CURR PERSONNEL	\$0.00				\$4.41	\$4.41		
FEDERAL MEDICAID PAYMENTS Total					\$0.00	\$432.34	-\$432.34	
LOCAL FUND	CONTINUING FULL TIME			\$0.00	\$0.00	\$0.00		
	CONTRACTUAL SERVICES - OTHER			\$0.00	-\$436.75	\$436.75		
	FRINGE BENEFITS - CURR PERSONNEL			\$0.00	\$0.00	\$0.00		
	LOCAL FUND Total			\$0.00	-\$436.75	\$436.75		
DIVISION OF QUALITY AND HEALTH OUTCOMES Total				\$0.00	-\$4.41	\$4.41		
70163	DIVISION OF CHILDREN'S HEALTH SERVICES			FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$159,073.91	-\$126,105.84	\$285,179.75
		CONTINUING FULL TIME - OTHERS	\$192,499.43		\$196,188.52	-\$3,689.09		
		CONTRACTUAL SERVICES - OTHER	\$0.00		\$1,250.25	-\$1,250.25		
		FRINGE BENEFITS - CURR PERSONNEL	\$149,253.79		\$60,930.32	\$88,323.47		
		OVERTIME PAY	\$0.00		\$279.03	-\$279.03		
		FEDERAL MEDICAID PAYMENTS Total			\$500,827.13	\$132,542.28	\$368,284.85	
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$190,351.81	-\$190,351.81		
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$1,469.49	-\$1,469.49		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
			LOCAL FUND Total		\$0.00	\$191,821.30	-\$191,821.30	
DIVISION OF CHILDREN'S HEALTH SERVICES Total				\$500,827.13	\$324,363.58	\$176,463.55		
70262	DIVISION OF PUBLIC AND PRIVATE PROVIDER SERVICES	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$9,508.17	-\$9,508.17		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$36.04	\$36.04		
			FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$9,472.13	-\$9,472.13	
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$9,508.17	\$9,508.17		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
			LOCAL FUND Total		\$0.00	-\$9,508.17	\$9,508.17	
		DIVISION OF PUBLIC AND PRIVATE PROVIDER SERVICES Total				\$0.00	-\$36.04	\$36.04
		70263	HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
CONTINUING FULL TIME	\$0.00				\$0.00	\$0.00		
CONTINUING FULL TIME - OTHERS	\$0.00				\$0.00	\$0.00		
CONTRACTUAL SERVICES - OTHER	\$0.00				-\$15,794.27	\$15,794.27		
FRINGE BENEFITS - CURR PERSONNEL	\$0.00				-\$97.24	\$97.24		
OVERTIME PAY	\$0.00				\$0.00	\$0.00		
FEDERAL MEDICAID PAYMENTS Total					\$0.00	-\$15,891.51	\$15,891.51	
LOCAL FUND	ADDITIONAL GROSS PAY			\$0.00	\$0.00	\$0.00		
	CONTINUING FULL TIME			\$0.00	\$0.00	\$0.00		
	CONTINUING FULL TIME - OTHERS			\$0.00	\$0.00	\$0.00		
	CONTRACTUAL SERVICES - OTHER			\$0.00	-\$25,616.53	\$25,616.53		
	FRINGE BENEFITS - CURR PERSONNEL			\$0.00	\$0.00	\$0.00		
	OVERTIME PAY			\$0.00	\$0.00	\$0.00		
	LOCAL FUND Total		\$0.00	-\$25,616.53	\$25,616.53			
HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVISION Total				\$0.00	-\$41,508.04	\$41,508.04		
70264	DIVISION OF REGULATIONS & POLICY MANAGEMENT	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$1,559.68	-\$1,559.68		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$35.04	\$35.04		
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$1,524.64	-\$1,524.64		
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$1,559.68	\$1,559.68		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
		LOCAL FUND Total		\$0.00	-\$1,559.68	\$1,559.68		
DIVISION OF REGULATIONS & POLICY MANAGEMENT Total				\$0.00	-\$35.04	\$35.04		
70270	LONG TERM CARE SUPPORT SERVICES DIVISION	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$0.00	\$29,241.78	-\$29,241.78		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$4,334.82	-\$4,334.82		
			GOVERNMENT SUBSIDIES & GRANTS	\$1,862,309.72	\$1,862,309.72	\$0.00		
		FEDERAL GRANT FUND - FPR Total		\$1,862,309.72	\$1,895,886.32	-\$33,576.60		
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$278,603.46	\$278,603.46		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$7.06	\$7.06		
			OVERTIME PAY	\$0.00	\$0.00	\$0.00		
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	-\$278,610.52	\$278,610.52		
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00		
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$437,018.47	\$437,018.47		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00		
			OVERTIME PAY	\$0.00	\$0.00	\$0.00		
			LOCAL FUND Total		\$0.00	-\$437,018.47	\$437,018.47	
LONG TERM CARE SUPPORT SERVICES DIVISION Total				\$1,862,309.72	\$1,180,257.33	\$682,052.39		

70271	LONG TERM CARE OVERSIGHT DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$3,584.51	-\$3,584.51
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$70.98	\$70.98
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$3,513.53	-\$3,513.53
		LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$3,584.51	\$3,584.51
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	-\$3,584.51	\$3,584.51
	LONG TERM CARE OVERSIGHT DIVISION Total			\$0.00	-\$70.98	\$70.98
70272	LONG TERM CARE OPERATIONS DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
			CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$4,958.75	-\$4,958.75
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$70.07	\$70.07
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$4,888.68	-\$4,888.68
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
			CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$4,958.75	\$4,958.75
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	-\$4,958.75	\$4,958.75
	LONG TERM CARE OPERATIONS DIVISION Total			\$0.00	-\$70.07	\$70.07
70273	INTAKE AND ASSESSMENT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
			CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$1,104.36	-\$1,104.36
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$57.72	\$57.72
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$1,046.64	-\$1,046.64
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
			CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	-\$1,104.36	\$1,104.36
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	-\$1,104.36	\$1,104.36
	INTAKE AND ASSESSMENT DIVISION Total			\$0.00	-\$57.72	\$57.72
PROGRAM OVERSIGHT Total				\$2,263,136.85	\$415,891.58	\$1,947,245.27
PROVIDER SERVICES						
70164	INPATIENT IN STATE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$18,386,192.74	\$18,386,192.74	\$0.00
		DEDICATED TAXES Total		\$18,386,192.74	\$18,386,192.74	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$83,711,890.68	\$87,362,562.16	-\$3,650,671.48
		FEDERAL MEDICAID PAYMENTS Total		\$83,711,890.68	\$87,362,562.16	-\$3,650,671.48
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$18,759,929.30	\$19,054,905.33	-\$294,976.03
		LOCAL FUND Total		\$18,759,929.30	\$19,054,905.33	-\$294,976.03
	INPATIENT IN STATE Total			\$120,858,012.72	\$124,803,660.23	-\$3,945,647.51
70165	INPATIENT CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$667,407.88	\$721,103.90	-\$53,696.02
		FEDERAL MEDICAID PAYMENTS Total		\$667,407.88	\$721,103.90	-\$53,696.02
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$42,640.07	\$191,685.85	-\$149,045.78
		LOCAL FUND Total		\$42,640.07	\$191,685.85	-\$149,045.78
	INPATIENT CHIP Total			\$710,047.95	\$912,789.75	-\$202,741.80
70166	INPATIENT - DSH PAYMENTS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$26,910,000.00	\$21,383,481.25	\$5,526,518.75
		FEDERAL MEDICAID PAYMENTS Total		\$26,910,000.00	\$21,383,481.25	\$5,526,518.75
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$9,200,000.00	\$9,164,349.11	\$35,650.89
		LOCAL FUND Total		\$9,200,000.00	\$9,164,349.11	\$35,650.89
	INPATIENT - DSH PAYMENTS Total			\$36,110,000.00	\$30,547,830.36	\$5,562,169.64
70167	INPATIENT - GME PAYMENTS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$272,410.61	\$272,410.60	\$0.01
		FEDERAL MEDICAID PAYMENTS Total		\$272,410.61	\$272,410.60	\$0.01
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$7,368,496.00	\$8,743,279.40	-\$1,374,783.40
		LOCAL FUND Total		\$7,368,496.00	\$8,743,279.40	-\$1,374,783.40
	INPATIENT - GME PAYMENTS Total			\$7,640,906.61	\$9,015,690.00	-\$1,374,783.39
70168	MENTAL HEALTH FACILITY SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$452,172.29	\$454,995.71	-\$2,823.42
		FEDERAL MEDICAID PAYMENTS Total		\$452,172.29	\$454,995.71	-\$2,823.42
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$234,305.77	\$195,570.40	\$38,735.37
		LOCAL FUND Total		\$234,305.77	\$195,570.40	\$38,735.37
	MENTAL HEALTH FACILITY SERVICES Total			\$686,478.06	\$650,566.11	\$35,911.95
70169	MENTAL HEALTH FACILITY SERVICES - DSH	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$0.00	\$0.00
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00
	MENTAL HEALTH FACILITY SERVICES - DSH Total			\$0.00	\$0.00	\$0.00
70170	PSYCHIATRIC RESIDENTIAL TREATMENT FACIL.	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$836,222.48	\$798,700.13	\$37,522.35
		FEDERAL MEDICAID PAYMENTS Total		\$836,222.48	\$798,700.13	\$37,522.35
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$333,535.09	\$342,300.04	-\$8,764.95
		LOCAL FUND Total		\$333,535.09	\$342,300.04	-\$8,764.95
	PSYCHIATRIC RESIDENTIAL TREATMENT FACIL. Total			\$1,169,757.57	\$1,141,000.17	\$28,757.40
70171	NURSING FACILITY IN STATE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$17,416,393.56	\$14,121,786.56	\$3,294,607.00
		DEDICATED TAXES Total		\$17,416,393.56	\$14,121,786.56	\$3,294,607.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$231,367,772.55	\$232,282,336.35	-\$914,563.80
		FEDERAL MEDICAID PAYMENTS Total		\$231,367,772.55	\$232,282,336.35	-\$914,563.80
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$73,067,132.82	\$82,504,317.15	-\$9,437,184.33
		LOCAL FUND Total		\$73,067,132.82	\$82,504,317.15	-\$9,437,184.33
	NURSING FACILITY IN STATE Total			\$321,851,298.93	\$328,908,440.06	-\$7,057,141.13
70172	NURSING HOME QUALITY OF CARE SERVICES	DEDICATED TAXES	CONTRACTUAL SERVICES - OTHER	\$110,000.00	\$110,000.00	\$0.00
		DEDICATED TAXES Total		\$110,000.00	\$110,000.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$90,000.00	\$54,801.06	\$35,198.94
		FEDERAL MEDICAID PAYMENTS Total		\$90,000.00	\$54,801.06	\$35,198.94
	NURSING HOME QUALITY OF CARE SERVICES Total			\$200,000.00	\$164,801.06	\$35,198.94
70173	ICF PRIVATE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$4,394,829.68	\$5,240,138.68	-\$845,309.00
		DEDICATED TAXES Total		\$4,394,829.68	\$5,240,138.68	-\$845,309.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$68,109,558.25	\$67,867,324.92	\$242,233.33
		FEDERAL MEDICAID PAYMENTS Total		\$68,109,558.25	\$67,867,324.92	\$242,233.33
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$24,512,727.71	\$23,845,857.73	\$666,869.98
		LOCAL FUND Total		\$24,512,727.71	\$23,845,857.73	\$666,869.98
	ICF PRIVATE Total			\$97,017,115.64	\$96,953,321.33	\$63,794.31
70174	PHYSICIAN SERVICES-MEDICAID	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$14,694,377.80	\$9,909,877.68	\$4,784,500.12
		FEDERAL MEDICAID PAYMENTS Total		\$14,694,377.80	\$9,909,877.68	\$4,784,500.12
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$5,238,984.34	\$4,948,371.06	\$290,613.28

		LOCAL FUND Total		\$5,238,984.34	\$4,948,371.06	\$290,613.28
		SPECIAL PURPOSE REVENUE FUNDS	GOVERNMENT SUBSIDIES & GRANTS	\$1,102,749.00	\$1,102,749.00	\$0.00
		SPECIAL PURPOSE REVENUE FUNDS Total		\$1,102,749.00	\$1,102,749.00	\$0.00
		PHYSICIAN SERVICES-MEDICAID Total		\$21,036,111.14	\$15,960,997.74	\$5,075,113.40
70175	PHYSICIAN SERVICES CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$63,858.91	\$81,283.19	-\$17,424.28
		FEDERAL MEDICAID PAYMENTS Total		\$63,858.91	\$81,283.19	-\$17,424.28
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$17,061.23	\$21,606.93	-\$4,545.70
		LOCAL FUND Total		\$17,061.23	\$21,606.93	-\$4,545.70
		PHYSICIAN SERVICES CHIP Total		\$80,920.14	\$102,890.12	-\$21,969.98
70176	OUTPATIENT HOSPITAL IN STATE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$5,546,079.76	\$5,546,079.76	\$0.00
		DEDICATED TAXES Total		\$5,546,079.76	\$5,546,079.76	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$10,790,848.73	\$15,566,663.75	-\$4,775,815.02
		FEDERAL MEDICAID PAYMENTS Total		\$10,790,848.73	\$15,566,663.75	-\$4,775,815.02
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$1,109,643.76	-\$1,109,643.76
		LOCAL FUND Total		\$0.00	\$1,109,643.76	-\$1,109,643.76
		OUTPATIENT HOSPITAL IN STATE Total		\$16,336,928.49	\$22,222,387.27	-\$5,885,458.78
70177	OUTPATIENT HOSPITAL CHIP	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$12,518.00	\$12,518.00	\$0.00
		DEDICATED TAXES Total		\$12,518.00	\$12,518.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$184,091.24	\$196,308.14	-\$12,216.90
		FEDERAL MEDICAID PAYMENTS Total		\$184,091.24	\$196,308.14	-\$12,216.90
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$52,183.18	-\$52,183.18
		LOCAL FUND Total		\$0.00	\$52,183.18	-\$52,183.18
		OUTPATIENT HOSPITAL CHIP Total		\$196,609.24	\$261,009.32	-\$64,400.08
70178	PRESCRIBED DRUGS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$35,246,022.23	\$17,240,945.05	\$18,005,077.18
		FEDERAL MEDICAID PAYMENTS Total		\$35,246,022.23	\$17,240,945.05	\$18,005,077.18
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$15,105,438.10	\$11,005,027.62	\$4,100,410.48
		LOCAL FUND Total		\$15,105,438.10	\$11,005,027.62	\$4,100,410.48
		PRESCRIBED DRUGS Total		\$50,351,460.33	\$28,245,972.67	\$22,105,487.66
70179	PRESCRIBED DRUGS - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$268,478.72	\$91,684.60	\$176,794.12
		FEDERAL MEDICAID PAYMENTS Total		\$268,478.72	\$91,684.60	\$176,794.12
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$88,519.66	\$24,371.86	\$64,147.80
		LOCAL FUND Total		\$88,519.66	\$24,371.86	\$64,147.80
		PRESCRIBED DRUGS - CHIP Total		\$356,998.38	\$116,056.46	\$240,941.92
70180	DENTAL SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,043,373.43	\$2,999,519.24	\$43,854.19
		FEDERAL MEDICAID PAYMENTS Total		\$3,043,373.43	\$2,999,519.24	\$43,854.19
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,232,545.75	\$1,285,508.46	-\$52,962.71
		LOCAL FUND Total		\$1,232,545.75	\$1,285,508.46	-\$52,962.71
		DENTAL SERVICES Total		\$4,275,919.18	\$4,285,027.70	-\$9,108.52
70181	DENTAL SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$107,353.06	\$113,739.15	-\$6,386.09
		FEDERAL MEDICAID PAYMENTS Total		\$107,353.06	\$113,739.15	-\$6,386.09
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$156,579.93	\$30,234.46	\$126,345.47
		LOCAL FUND Total		\$156,579.93	\$30,234.46	\$126,345.47
		DENTAL SERVICES - CHIP Total		\$263,932.99	\$143,973.61	\$119,959.38
70182	OTHER PRACTITIONERS' SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$554,415.31	\$570,955.97	-\$16,540.66
		FEDERAL MEDICAID PAYMENTS Total		\$554,415.31	\$570,955.97	-\$16,540.66
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$237,620.85	\$244,695.42	-\$7,074.57
		LOCAL FUND Total		\$237,620.85	\$244,695.42	-\$7,074.57
		OTHER PRACTITIONERS' SERVICES Total		\$792,036.16	\$815,651.39	-\$23,615.23
70183	OTHER PRACTITIONERS' SERVICES CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$178,168.53	\$285,769.39	-\$107,600.86
		FEDERAL MEDICAID PAYMENTS Total		\$178,168.53	\$285,769.39	-\$107,600.86
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$47,576.44	\$75,964.01	-\$28,387.57
		LOCAL FUND Total		\$47,576.44	\$75,964.01	-\$28,387.57
		OTHER PRACTITIONERS' SERVICES CHIP Total		\$225,744.97	\$361,733.40	-\$135,988.43
70184	CLINIC SERVICES - PRIVATE	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,048,696.16	\$4,298,725.28	-\$1,250,029.12
		FEDERAL MEDICAID PAYMENTS Total		\$3,048,696.16	\$4,298,725.28	-\$1,250,029.12
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,106,584.07	\$1,841,432.54	\$265,151.53
		LOCAL FUND Total		\$2,106,584.07	\$1,841,432.54	\$265,151.53
		CLINIC SERVICES - PRIVATE Total		\$5,155,280.23	\$6,140,157.82	-\$984,877.59
70185	CLINIC SERVICES - PRIVATE CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,345.61	\$3,019.90	\$325.71
		FEDERAL MEDICAID PAYMENTS Total		\$3,345.61	\$3,019.90	\$325.71
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$871.62	\$802.76	\$68.86
		LOCAL FUND Total		\$871.62	\$802.76	\$68.86
		CLINIC SERVICES - PRIVATE CHIP Total		\$4,217.23	\$3,822.66	\$394.57
70186	CLINIC SERVICES - MENTAL HEALTH	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$252,827.45	\$156,594.15	\$96,233.30
		FEDERAL MEDICAID PAYMENTS Total		\$252,827.45	\$156,594.15	\$96,233.30
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$138,919.46	\$67,111.79	\$71,807.67
		LOCAL FUND Total		\$138,919.46	\$67,111.79	\$71,807.67
		CLINIC SERVICES - MENTAL HEALTH Total		\$391,746.91	\$223,705.94	\$168,040.97
70187	CLINIC SERVICES - MENTAL HEALTH CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,300.00	\$2,015.27	\$284.73
		FEDERAL MEDICAID PAYMENTS Total		\$2,300.00	\$2,015.27	\$284.73
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$535.70	-\$535.70
		LOCAL FUND Total		\$0.00	\$535.70	-\$535.70
		CLINIC SERVICES - MENTAL HEALTH CHIP Total		\$2,300.00	\$2,550.97	-\$250.97
70188	CLINIC SERVICES - MHRS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$170,985,729.40	\$170,985,729.41	-\$0.01
		FEDERAL MEDICAID PAYMENTS Total		\$170,985,729.40	\$170,985,729.41	-\$0.01
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$4,689,815.36	\$4,689,815.36	\$0.00
		LOCAL FUND Total		\$4,689,815.36	\$4,689,815.36	\$0.00
		CLINIC SERVICES - MHRS Total		\$175,675,544.76	\$175,675,544.77	-\$0.01
70189	CLINIC SERVICES - MHRS CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,902,000.00	\$2,872,964.35	\$29,035.65
		FEDERAL MEDICAID PAYMENTS Total		\$2,902,000.00	\$2,872,964.35	\$29,035.65
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00
		CLINIC SERVICES - MHRS CHIP Total		\$2,902,000.00	\$2,872,964.35	\$29,035.65
70190	LABORATORY & RADIOLOGICAL SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,487,313.66	\$3,706,463.85	-\$219,150.19
		FEDERAL MEDICAID PAYMENTS Total		\$3,487,313.66	\$3,706,463.85	-\$219,150.19
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,526,563.00	\$1,587,074.31	-\$60,511.31
		LOCAL FUND Total		\$1,526,563.00	\$1,587,074.31	-\$60,511.31
		LABORATORY & RADIOLOGICAL SERVICES Total		\$5,013,876.66	\$5,293,538.16	-\$279,661.50
70191	LABORATORY & RADIOLOGICAL SERVICES -CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$42,985.21	\$44,578.83	-\$1,593.62
		FEDERAL MEDICAID PAYMENTS Total		\$42,985.21	\$44,578.83	-\$1,593.62
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$11,511.26	\$11,850.07	-\$338.81

		LOCAL FUND Total		\$11,511.26	\$11,850.07	-\$338.81
	LABORATORY & RADIOLOGICAL SERVICES -CHIP Total			\$54,496.47	\$56,428.90	-\$1,932.43
70192	HOME HEALTH SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,626,594.94	\$4,355,647.80	\$270,947.14
		FEDERAL MEDICAID PAYMENTS Total		\$4,626,594.94	\$4,355,647.80	\$270,947.14
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,992,440.69	\$1,872,839.98	\$119,600.71
		LOCAL FUND Total		\$1,992,440.69	\$1,872,839.98	\$119,600.71
	HOME HEALTH SERVICES Total			\$6,619,035.63	\$6,228,487.78	\$390,547.85
70193	HOME HEALTH SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$40,740.47	\$0.00	\$40,740.47
		FEDERAL MEDICAID PAYMENTS Total		\$40,740.47	\$0.00	\$40,740.47
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,429.74	\$0.00	\$1,429.74
		LOCAL FUND Total		\$1,429.74	\$0.00	\$1,429.74
	HOME HEALTH SERVICES - CHIP Total			\$42,170.21	\$0.00	\$42,170.21
70194	STERILIZATIONS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,651.02	\$11,909.68	-\$7,258.66
		FEDERAL MEDICAID PAYMENTS Total		\$4,651.02	\$11,909.68	-\$7,258.66
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,993.29	\$4,989.77	-\$2,996.48
		LOCAL FUND Total		\$1,993.29	\$4,989.77	-\$2,996.48
	STERILIZATIONS Total			\$6,644.31	\$16,899.45	-\$10,255.14
70195	EPSDT-MEDICAID	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$332,756.95	\$330,397.87	\$2,359.08
		FEDERAL MEDICAID PAYMENTS Total		\$332,756.95	\$330,397.87	\$2,359.08
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$142,810.12	\$141,570.40	\$1,239.72
		LOCAL FUND Total		\$142,810.12	\$141,570.40	\$1,239.72
	EPSDT-MEDICAID Total			\$475,567.07	\$471,968.27	\$3,598.80
70196	EPSDT SCREENING SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$16,468.79	\$9,146.56	\$7,322.23
		FEDERAL MEDICAID PAYMENTS Total		\$16,468.79	\$9,146.56	\$7,322.23
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,877.78	\$2,431.37	\$446.41
		LOCAL FUND Total		\$2,877.78	\$2,431.37	\$446.41
	EPSDT SCREENING SERVICES - CHIP Total			\$19,346.57	\$11,577.93	\$7,768.64
70197	MEDICAID PART A	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$11,650,528.44	\$11,782,975.96	-\$132,447.52
		FEDERAL MEDICAID PAYMENTS Total		\$11,650,528.44	\$11,782,975.96	-\$132,447.52
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$5,029,083.62	\$5,049,846.84	-\$20,763.22
		LOCAL FUND Total		\$5,029,083.62	\$5,049,846.84	-\$20,763.22
	MEDICAID PART A Total			\$16,679,612.06	\$16,832,822.80	-\$153,210.74
70198	MEDICAID PART B	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$56,074,462.29	\$56,060,247.18	\$14,215.11
		FEDERAL MEDICAID PAYMENTS Total		\$56,074,462.29	\$56,060,247.18	\$14,215.11
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$24,074,769.55	\$24,025,820.22	\$48,949.33
		LOCAL FUND Total		\$24,074,769.55	\$24,025,820.22	\$48,949.33
	MEDICAID PART B Total			\$80,149,231.84	\$80,086,067.40	\$63,164.44
70199	MEDICAID PART B - NON FFP	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$4,867,552.58	\$4,767,971.30	\$99,581.28
		LOCAL FUND Total		\$4,867,552.58	\$4,767,971.30	\$99,581.28
				\$4,867,552.58	\$4,767,971.30	\$99,581.28
				\$4,867,552.58	\$4,767,971.30	\$99,581.28
70200	MANAGED CARE ORGANIZATIONS (MCO)	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$132,432,599.37	\$132,432,599.37	\$0.00
		DEDICATED TAXES Total		\$132,432,599.37	\$132,432,599.37	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$414,507,791.82	\$343,262,896.25	\$71,244,895.57
		FEDERAL MEDICAID PAYMENTS Total		\$414,507,791.82	\$343,262,896.25	\$71,244,895.57
	MANAGED CARE ORGANIZATIONS (MCO) Total			\$102,848,246.31	\$88,438,585.86	\$14,409,660.45
70201	MANAGED CARE ORGANIZATIONS (MCO) - CHIP	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$102,848,246.31	\$88,438,585.86	\$14,409,660.45
		LOCAL FUND Total		\$102,848,246.31	\$88,438,585.86	\$14,409,660.45
				\$649,788,637.50	\$564,134,081.48	\$85,654,556.02
				\$3,172,680.88	\$3,172,680.88	\$0.00
	MANAGED CARE ORGANIZATIONS (MCO) - CHIP Total			\$3,172,680.88	\$3,172,680.88	\$0.00
70202	CASSIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$38,867,185.45	\$40,941,774.82	-\$2,074,589.37
		FEDERAL MEDICAID PAYMENTS Total		\$38,867,185.45	\$40,941,774.82	-\$2,074,589.37
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$11,790,136.49	\$11,366,555.69	\$423,580.80
		LOCAL FUND Total		\$11,790,136.49	\$11,366,555.69	\$423,580.80
	MANAGED CARE ORGANIZATIONS (MCO) - CHIP Total			\$53,830,002.82	\$55,481,011.39	-\$1,651,008.57
70203	PERSONAL CARE SERVICES	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$934,443.57	\$934,443.57	\$0.00
		DEDICATED TAXES Total		\$934,443.57	\$934,443.57	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$112,019,121.42	\$112,019,121.42	\$0.00
		FEDERAL MEDICAID PAYMENTS Total		\$112,019,121.42	\$112,019,121.42	\$0.00
	CASSIP Total			\$51,153,970.31	\$49,789,209.90	\$1,364,760.41
70205	HOSPICE BENEFITS	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$51,153,970.31	\$49,789,209.90	\$1,364,760.41
		LOCAL FUND Total		\$51,153,970.31	\$49,789,209.90	\$1,364,760.41
				\$164,107,535.30	\$162,742,774.89	\$1,364,760.41
				\$164,107,535.30	\$162,742,774.89	\$1,364,760.41
70206	FEDERALLY-QUALIFIED HEALTH CENTER	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$99,110,008.66	\$100,835,987.86	-\$1,725,979.20
		FEDERAL MEDICAID PAYMENTS Total		\$99,110,008.66	\$100,835,987.86	-\$1,725,979.20
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$42,494,987.00	\$43,215,483.77	-\$720,496.77
		LOCAL FUND Total		\$42,494,987.00	\$43,215,483.77	-\$720,496.77
	PERSONAL CARE SERVICES Total			\$141,604,995.66	\$144,051,471.63	-\$2,446,475.97
70207	FEDERALLY-QUALIFIED HEALTH CENTER - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,929,292.72	\$2,341,087.90	-\$411,795.18
		FEDERAL MEDICAID PAYMENTS Total		\$1,929,292.72	\$2,341,087.90	-\$411,795.18
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$826,839.74	\$1,003,323.48	-\$176,483.74
		LOCAL FUND Total		\$826,839.74	\$1,003,323.48	-\$176,483.74
	HOSPICE BENEFITS Total			\$2,756,132.46	\$3,344,411.38	-\$588,278.92
70208	FEDERALLY-QUALIFIED HEALTH CENTER	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$6,116,655.26	\$5,916,965.29	\$199,689.97
		FEDERAL MEDICAID PAYMENTS Total		\$6,116,655.26	\$5,916,965.29	\$199,689.97
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,576,652.25	\$2,514,530.30	\$62,121.95
		LOCAL FUND Total		\$2,576,652.25	\$2,514,530.30	\$62,121.95
	FEDERALLY-QUALIFIED HEALTH CENTER Total			\$8,693,307.51	\$8,431,495.59	\$261,811.92
70209	NON-EMERGENCY MEDICAL TRANSPORTATION	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$124,321.29	\$124,321.29	\$0.00
		FEDERAL MEDICAID PAYMENTS Total		\$124,321.29	\$124,321.29	\$0.00
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$67,400.60	\$33,047.43	\$34,353.17
		LOCAL FUND Total		\$67,400.60	\$33,047.43	\$34,353.17
	FEDERALLY-QUALIFIED HEALTH CENTER - CHIP Total			\$191,721.89	\$157,368.72	\$34,353.17
70209	NON-EMERGENCY MEDICAL TRANSPORT. - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$9,611,372.67	\$10,541,563.50	-\$930,190.83
		FEDERAL MEDICAID PAYMENTS Total		\$9,611,372.67	\$10,541,563.50	-\$930,190.83
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$5,312,068.38	\$4,517,808.33	\$794,260.05
		LOCAL FUND Total		\$5,312,068.38	\$4,517,808.33	\$794,260.05
	NON-EMERGENCY MEDICAL TRANSPORTATION Total			\$14,923,441.05	\$15,059,371.83	-\$135,930.78
70209	NON-EMERGENCY MEDICAL TRANSPORT. - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$76,424.76	\$89,481.90	-\$13,057.14
		FEDERAL MEDICAID PAYMENTS Total		\$76,424.76	\$89,481.90	-\$13,057.14
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$25,912.27	\$22,524.09	\$3,388.18
		LOCAL FUND Total		\$25,912.27	\$22,524.09	\$3,388.18
	NON-EMERGENCY MEDICAL TRANSPORT. - CHIP Total			\$102,337.03	\$112,005.99	-\$9,668.96

70210	PHYSICAL THERAPY	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$42,001.28	\$34,388.23	\$7,613.05
		FEDERAL MEDICAID PAYMENTS Total		\$42,001.28	\$34,388.23	\$7,613.05
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$30,500.55	\$14,737.81	\$15,762.74
		LOCAL FUND Total		\$30,500.55	\$14,737.81	\$15,762.74
	PHYSICAL THERAPY Total			\$72,501.83	\$49,126.04	\$23,375.79
70211	PHYSICAL THERAPY - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,295.63	\$932.26	\$363.37
		FEDERAL MEDICAID PAYMENTS Total		\$1,295.63	\$932.26	\$363.37
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$564.66	\$247.82	\$316.84
		LOCAL FUND Total		\$564.66	\$247.82	\$316.84
	PHYSICAL THERAPY - CHIP Total			\$1,860.29	\$1,180.08	\$680.21
70212	PROSTHETIC DEVICES, DENTURES, EYEGLASSES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$956,525.28	\$879,048.27	\$77,477.01
		FEDERAL MEDICAID PAYMENTS Total		\$956,525.28	\$879,048.27	\$77,477.01
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$410,082.26	\$376,735.01	\$33,347.25
		LOCAL FUND Total		\$410,082.26	\$376,735.01	\$33,347.25
	PROSTHETIC DEVICES, DENTURES, EYEGLASSES Total			\$1,366,607.54	\$1,255,783.28	\$110,824.26
70213	PROSTHETC DVCS,DENTURES,EYEGLASSES-CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,428.49	\$6,884.05	-\$2,455.56
		FEDERAL MEDICAID PAYMENTS Total		\$4,428.49	\$6,884.05	-\$2,455.56
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,226.56	\$1,829.94	-\$603.38
		LOCAL FUND Total		\$1,226.56	\$1,829.94	-\$603.38
	PROSTHETC DVCS,DENTURES,EYEGLASSES-CHIP Total			\$5,655.05	\$8,713.99	-\$3,058.94
70214	NURSE MID-WIFE	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$47,167.08	\$59,669.77	-\$12,502.69
		FEDERAL MEDICAID PAYMENTS Total		\$47,167.08	\$59,669.77	-\$12,502.69
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$25,214.46	\$23,094.17	\$2,120.29
		LOCAL FUND Total		\$25,214.46	\$23,094.17	\$2,120.29
	NURSE MID-WIFE Total			\$72,381.54	\$82,763.94	-\$10,382.40
70215	EMERGENCY HOSPITAL SERVICES	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$928,640.95	\$928,640.95	\$0.00
		DEDICATED TAXES Total		\$928,640.95	\$928,640.95	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,677,530.87	\$4,320,713.10	-\$643,182.23
		FEDERAL MEDICAID PAYMENTS Total		\$3,677,530.87	\$4,320,713.10	-\$643,182.23
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$202,996.54	\$951,986.62	-\$748,990.08
		LOCAL FUND Total		\$202,996.54	\$951,986.62	-\$748,990.08
		EMERGENCY HOSPITAL SERVICES Total		\$4,809,168.36	\$6,201,240.67	-\$1,392,172.31
70216	EMERGENCY HOSPITAL SERVICES - CHIP	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$9,167.00	\$9,167.00	\$0.00
		DEDICATED TAXES Total		\$9,167.00	\$9,167.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$104,485.91	\$113,050.60	-\$8,564.69
		FEDERAL MEDICAID PAYMENTS Total		\$104,485.91	\$113,050.60	-\$8,564.69
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$28,000.00	\$30,051.42	-\$2,051.42
		LOCAL FUND Total		\$28,000.00	\$30,051.42	-\$2,051.42
		EMERGENCY HOSPITAL SERVICES - CHIP Total		\$141,652.91	\$152,269.02	-\$10,616.11
70217	NURSE PRACTITIONER SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,020,775.27	\$4,376,645.91	-\$1,355,870.64
		FEDERAL MEDICAID PAYMENTS Total		\$3,020,775.27	\$4,376,645.91	-\$1,355,870.64
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,734,617.97	\$1,873,809.70	-\$139,191.73
		LOCAL FUND Total		\$1,734,617.97	\$1,873,809.70	-\$139,191.73
	NURSE PRACTITIONER SERVICES Total			\$4,755,393.24	\$6,250,455.61	-\$1,495,062.37
70218	NURSE PRACTITIONER SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$8,117.37	\$7,461.53	\$655.84
		FEDERAL MEDICAID PAYMENTS Total		\$8,117.37	\$7,461.53	\$655.84
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,157.78	\$1,983.44	\$174.34
		LOCAL FUND Total		\$2,157.78	\$1,983.44	\$174.34
	NURSE PRACTITIONER SERVICES - CHIP Total			\$10,275.15	\$9,444.97	\$830.18
70219	PRIVATE DUTY NURSING	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$11,731,792.84	\$12,395,300.38	-\$663,507.54
		FEDERAL MEDICAID PAYMENTS Total		\$11,731,792.84	\$12,395,300.38	-\$663,507.54
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$5,037,239.79	\$5,316,424.34	-\$279,184.55
		LOCAL FUND Total		\$5,037,239.79	\$5,316,424.34	-\$279,184.55
		PRIVATE DUTY NURSING Total		\$16,769,032.63	\$17,711,724.72	-\$942,692.09
70221	DURABLE MED EQUIP (DME)-MEDICAID	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$8,111,783.90	\$11,494,988.47	-\$3,383,204.57
		FEDERAL MEDICAID PAYMENTS Total		\$8,111,783.90	\$11,494,988.47	-\$3,383,204.57
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$3,476,478.81	\$4,926,401.63	-\$1,449,922.82
		LOCAL FUND Total		\$3,476,478.81	\$4,926,401.63	-\$1,449,922.82
	DURABLE MED EQUIP (DME)-MEDICAID Total			\$11,588,262.71	\$16,421,390.10	-\$4,833,127.39
70222	DURABLE MED EQUIP (DME)-MEDICAID - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,542.50	\$1,858.06	\$684.44
		FEDERAL MEDICAID PAYMENTS Total		\$2,542.50	\$1,858.06	\$684.44
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$653.45	\$493.91	\$159.54
		LOCAL FUND Total		\$653.45	\$493.91	\$159.54
		DURABLE MED EQUIP (DME)-MEDICAID - CHIP Total		\$3,195.95	\$2,351.97	\$843.98
70223	COBRA/RECIPIENT OOP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$29,810.93	\$116,834.37	-\$87,023.44
		FEDERAL MEDICAID PAYMENTS Total		\$29,810.93	\$116,834.37	-\$87,023.44
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$48,776.11	\$50,071.87	-\$1,295.76
		LOCAL FUND Total		\$48,776.11	\$50,071.87	-\$1,295.76
	COBRA/RECIPIENT OOP Total			\$78,587.04	\$166,906.24	-\$88,319.20
70224	IMMIGRANT KIDS	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
		DEDICATED TAXES Total		\$0.00	\$0.00	\$0.00
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$19,420,942.63	\$22,361,961.02	-\$2,941,018.39
		LOCAL FUND Total		\$19,420,942.63	\$22,361,961.02	-\$2,941,018.39
	IMMIGRANT KIDS Total			\$19,420,942.63	\$22,361,961.02	-\$2,941,018.39
70225	OPTIONAL STATE SUPPLEMENT PAYMENTS	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$5,403,324.22	\$4,766,967.07	\$636,357.15
		LOCAL FUND Total		\$5,403,324.22	\$4,766,967.07	\$636,357.15
		OPTIONAL STATE SUPPLEMENT PAYMENTS Total		\$5,403,324.22	\$4,766,967.07	\$636,357.15
70226	PART-D CLAWBACK	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$28,301,501.84	\$28,563,378.19	-\$261,876.35
		LOCAL FUND Total		\$28,301,501.84	\$28,563,378.19	-\$261,876.35
		PART-D CLAWBACK Total		\$28,301,501.84	\$28,563,378.19	-\$261,876.35
70228	IDD WAIVER	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$258,687,388.69	\$259,442,772.69	-\$755,384.00
		FEDERAL MEDICAID PAYMENTS Total		\$258,687,388.69	\$259,442,772.69	-\$755,384.00
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$7,691,068.21	\$8,187,025.16	-\$495,956.95
		LOCAL FUND Total		\$7,691,068.21	\$8,187,025.16	-\$495,956.95
	IDD WAIVER Total			\$266,378,456.90	\$267,629,797.85	-\$1,251,340.95
70229	EPD WAIVER	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$124,991,790.82	\$130,126,432.87	-\$5,134,642.05
		FEDERAL MEDICAID PAYMENTS Total		\$124,991,790.82	\$130,126,432.87	-\$5,134,642.05
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$47,575,812.83	\$56,086,767.17	-\$8,510,954.34
		LOCAL FUND Total		\$47,575,812.83	\$56,086,767.17	-\$8,510,954.34
	EPD WAIVER Total			\$172,567,603.65	\$186,213,200.04	-\$13,645,596.39
70230	ADULT DAY HEALTH	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,012,808.65	\$2,029,038.64	-\$16,229.99

		FEDERAL MEDICAID PAYMENTS Total		\$2,012,808.65	\$2,029,038.64	-\$16,229.99
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$871,517.99	\$869,587.90	\$1,930.09
		LOCAL FUND Total		\$871,517.99	\$869,587.90	\$1,930.09
		ADULT DAY HEALTH Total		\$2,884,326.64	\$2,898,626.54	-\$14,299.90
70231	MCO-NEWLY ELIGIBLE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$18,518,324.07	\$18,518,324.07	\$0.00
		DEDICATED TAXES Total		\$18,518,324.07	\$18,518,324.07	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$614,643,230.01	\$607,866,798.85	\$6,776,431.16
		FEDERAL MEDICAID PAYMENTS Total		\$614,643,230.01	\$607,866,798.85	\$6,776,431.16
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$74,598,428.48	\$67,697,743.72	\$6,900,684.76
		LOCAL FUND Total		\$74,598,428.48	\$67,697,743.72	\$6,900,684.76
		MCO-NEWLY ELIGIBLE Total		\$707,759,982.56	\$694,082,866.64	\$13,677,115.92
70232	EMERGENCY MEDICAID (NON MEDICAID POP.)	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$4,470,555.00	\$4,470,555.00	\$0.00
		DEDICATED TAXES Total		\$4,470,555.00	\$4,470,555.00	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$34,709,992.89	\$32,781,746.03	\$1,928,246.86
		FEDERAL MEDICAID PAYMENTS Total		\$34,709,992.89	\$32,781,746.03	\$1,928,246.86
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,889,942.22	\$9,666,778.90	-\$7,776,836.68
		LOCAL FUND Total		\$1,889,942.22	\$9,666,778.90	-\$7,776,836.68
		EMERGENCY MEDICAID (NON MEDICAID POP.) Total		\$41,070,490.11	\$46,919,079.93	-\$5,848,589.82
70233	ICF SUPPLEMENTAL PAYMENTS	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$780,000.00	\$0.00	\$780,000.00
		DEDICATED TAXES Total		\$780,000.00	\$0.00	\$780,000.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,820,000.00	\$0.00	\$1,820,000.00
		FEDERAL MEDICAID PAYMENTS Total		\$1,820,000.00	\$0.00	\$1,820,000.00
		ICF SUPPLEMENTAL PAYMENTS Total		\$2,600,000.00	\$0.00	\$2,600,000.00
70234	APRA ASARS: ADULT SUBSTANCE ABUSE	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,502,039.37	\$1,681,838.68	-\$179,799.31
		FEDERAL MEDICAID PAYMENTS Total		\$1,502,039.37	\$1,681,838.68	-\$179,799.31
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$81,072.23	\$81,072.23	\$0.00
		LOCAL FUND Total		\$81,072.23	\$81,072.23	\$0.00
		APRA ASARS: ADULT SUBSTANCE ABUSE Total		\$1,583,111.60	\$1,762,910.91	-\$179,799.31
70235	APRA ASTEP: CHILD SUBSTANCE ABUSE	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$5,557.58	\$113,225.13	-\$107,667.55
		FEDERAL MEDICAID PAYMENTS Total		\$5,557.58	\$113,225.13	-\$107,667.55
		APRA ASTEP: CHILD SUBSTANCE ABUSE Total		\$5,557.58	\$113,225.13	-\$107,667.55
70236	MCO- EXPANSION POPLULATION	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$18,975,533.26	\$19,056,894.76	-\$81,361.50
		FEDERAL MEDICAID PAYMENTS Total		\$18,975,533.26	\$19,056,894.76	-\$81,361.50
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,114,759.70	\$2,117,432.75	-\$2,673.05
		LOCAL FUND Total		\$2,114,759.70	\$2,117,432.75	-\$2,673.05
		MCO- EXPANSION POPLULATION Total		\$21,090,292.96	\$21,174,327.51	-\$84,034.55
70237	DHCF - HEALTH HOMES I	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$9,485.40	\$264.08	\$9,221.32
		FEDERAL MEDICAID PAYMENTS Total		\$9,485.40	\$264.08	\$9,221.32
		DHCF - HEALTH HOMES I Total		\$9,485.40	\$264.08	\$9,221.32
70238	HEALTH HOMES II	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,290,381.74	\$1,378,028.79	-\$87,647.05
		FEDERAL MEDICAID PAYMENTS Total		\$1,290,381.74	\$1,378,028.79	-\$87,647.05
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$553,020.75	\$590,583.58	-\$37,562.83
		LOCAL FUND Total		\$553,020.75	\$590,583.58	-\$37,562.83
		HEALTH HOMES II Total		\$1,843,402.49	\$1,968,612.37	-\$125,209.88
70239	PROGRAM OF ALL-INCLUSIVE CARE (PACE)	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,804,201.85	\$4,098,962.58	-\$294,760.73
		FEDERAL MEDICAID PAYMENTS Total		\$3,804,201.85	\$4,098,962.58	-\$294,760.73
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,776,043.65	\$1,756,698.25	\$19,345.40
		LOCAL FUND Total		\$1,776,043.65	\$1,756,698.25	\$19,345.40
		PROGRAM OF ALL-INCLUSIVE CARE (PACE) Total		\$5,580,245.50	\$5,855,660.83	-\$275,415.33
70241	MENTAL HEALTH FACILITY - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$64,625.09	\$32,354.33	\$32,270.76
		FEDERAL MEDICAID PAYMENTS Total		\$64,625.09	\$32,354.33	\$32,270.76
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$7,178.82	\$8,600.52	-\$1,421.70
		LOCAL FUND Total		\$7,178.82	\$8,600.52	-\$1,421.70
		MENTAL HEALTH FACILITY - CHIP Total		\$71,803.91	\$40,954.85	\$30,849.06
70242	CASSIP - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$5,211,222.99	\$5,713,623.14	-\$502,400.15
		FEDERAL MEDICAID PAYMENTS Total		\$5,211,222.99	\$5,713,623.14	-\$502,400.15
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,387,862.27	\$1,489,016.98	-\$101,154.71
		LOCAL FUND Total		\$1,387,862.27	\$1,489,016.98	-\$101,154.71
		CASSIP - CHIP Total		\$6,599,085.26	\$7,202,640.12	-\$603,554.86
70243	IFS WAIVER	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,762,466.30	\$1,361,780.67	\$400,685.63
		FEDERAL MEDICAID PAYMENTS Total		\$1,762,466.30	\$1,361,780.67	\$400,685.63
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$83,018.86	\$83,018.86	\$0.00
		LOCAL FUND Total		\$83,018.86	\$83,018.86	\$0.00
		IFS WAIVER Total		\$1,845,485.16	\$1,444,799.53	\$400,685.63
70244	DC PUBLIC SCHOOLS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$8,000,000.00	\$39,751,857.89	-\$31,751,857.89
		FEDERAL MEDICAID PAYMENTS Total		\$8,000,000.00	\$39,751,857.89	-\$31,751,857.89
		DC PUBLIC SCHOOLS Total		\$8,000,000.00	\$39,751,857.89	-\$31,751,857.89
70245	DC PUBLIC SCHOOLS - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$200,000.00	\$835,323.30	-\$635,323.30
		FEDERAL MEDICAID PAYMENTS Total		\$200,000.00	\$835,323.30	-\$635,323.30
		DC PUBLIC SCHOOLS - CHIP Total		\$200,000.00	\$835,323.30	-\$635,323.30
70246	DC CHARTER SCHOOLS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,000,000.00	\$5,739,467.98	-\$1,739,467.98
		FEDERAL MEDICAID PAYMENTS Total		\$4,000,000.00	\$5,739,467.98	-\$1,739,467.98
		DC CHARTER SCHOOLS Total		\$4,000,000.00	\$5,739,467.98	-\$1,739,467.98
70247	DC CHARTER SCHOOLS - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$54,771.94	\$54,771.94	\$0.00
		FEDERAL MEDICAID PAYMENTS Total		\$54,771.94	\$54,771.94	\$0.00
		DC CHARTER SCHOOLS - CHIP Total		\$54,771.94	\$54,771.94	\$0.00
70248	OSSE-CHILDREN W/SPCL NEEDS TRNSPT	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$7,944,259.50	\$11,047,838.50	-\$3,103,579.00
		FEDERAL MEDICAID PAYMENTS Total		\$7,944,259.50	\$11,047,838.50	-\$3,103,579.00
		OSSE-CHILDREN W/SPCL NEEDS TRNSPT Total		\$7,944,259.50	\$11,047,838.50	-\$3,103,579.00
70249	OSSE-CHILDREN W/SPCL NEEDS TRNSPT - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$717,664.68	\$717,664.68	\$0.00
		FEDERAL MEDICAID PAYMENTS Total		\$717,664.68	\$717,664.68	\$0.00
		OSSE-CHILDREN W/SPCL NEEDS TRNSPT - CHIP Total		\$717,664.68	\$717,664.68	\$0.00
70250	DBH - REHAB OPTION	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,000,000.00	\$2,128,970.58	-\$128,970.58
		FEDERAL MEDICAID PAYMENTS Total		\$2,000,000.00	\$2,128,970.58	-\$128,970.58
		DBH - REHAB OPTION Total		\$2,000,000.00	\$2,128,970.58	-\$128,970.58
70251	DBH - REHAB OPTION - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$11,600.00	\$16,552.41	-\$4,952.41
		FEDERAL MEDICAID PAYMENTS Total		\$11,600.00	\$16,552.41	-\$4,952.41
		DBH - REHAB OPTION - CHIP Total		\$11,600.00	\$16,552.41	-\$4,952.41
70252	SAINT ELIZABETHS HOSPITAL	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,300,000.00	\$882,967.50	\$417,032.50
		FEDERAL MEDICAID PAYMENTS Total		\$1,300,000.00	\$882,967.50	\$417,032.50
		SAINT ELIZABETHS HOSPITAL Total		\$1,300,000.00	\$882,967.50	\$417,032.50

70253	ST ELIZBETHS HSPTL DSH (M.H. FCLTY DSH)	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,987,394.00	\$5,766,606.00	-\$779,212.00
		FEDERAL MEDICAID PAYMENTS Total		\$4,987,394.00	\$5,766,606.00	-\$779,212.00
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00
ST ELIZBETHS HSPTL DSH (M.H. FCLTY DSH) Total						
70254	CHILD & FAMILY SERVICES (CFSa)	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$500,000.00	\$552,607.61	-\$52,607.61
		FEDERAL MEDICAID PAYMENTS Total		\$500,000.00	\$552,607.61	-\$52,607.61
CHILD & FAMILY SERVICES (CFSa) Total						
70255	FIRE & EMS SVS. (AMBULANCE)	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$84,100,000.00	\$90,126,350.87	-\$6,026,350.87
		FEDERAL MEDICAID PAYMENTS Total		\$84,100,000.00	\$90,126,350.87	-\$6,026,350.87
FIRE & EMS SVS. (AMBULANCE) Total						
70256	FIRE & EMS SVS. (AMBULANCE) - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$859,654.02	\$859,654.02	\$0.00
		FEDERAL MEDICAID PAYMENTS Total		\$859,654.02	\$859,654.02	\$0.00
FIRE & EMS SVS. (AMBULANCE) - CHIP Total						
70258	DBH - DENTAL OPTION	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$22,700.00	\$0.00	\$22,700.00
		FEDERAL MEDICAID PAYMENTS Total		\$22,700.00	\$0.00	\$22,700.00
DBH - DENTAL OPTION Total						
70259	MCO ALLIANCE	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$157,728,008.66	\$159,904,535.83	-\$2,176,527.17
		LOCAL FUND Total		\$157,728,008.66	\$159,904,535.83	-\$2,176,527.17
MCO ALLIANCE Total						
70451	BEHAVIORAL HEALTH TRANSFORMATION WAIVER - MEDICAID	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,772,186.20	\$1,772,186.20	\$0.00
		FEDERAL MEDICAID PAYMENTS Total		\$1,772,186.20	\$1,772,186.20	\$0.00
BEHAVIORAL HEALTH TRANSFORMATION WAIVER - MEDICAID Total						
70456	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$182,166.39	\$179,900.36	\$2,266.03
		FEDERAL MEDICAID PAYMENTS Total		\$182,166.39	\$179,900.36	\$2,266.03
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$49,031.57	\$47,821.62	\$1,209.95
		LOCAL FUND Total		\$49,031.57	\$47,821.62	\$1,209.95
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY - CHIP Total						
70480	ALLIANCE EMERGENCY MEDICAL TRANSPORT	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,416,093.00	\$2,118,263.84	\$297,829.16
		LOCAL FUND Total		\$2,416,093.00	\$2,118,263.84	\$297,829.16
ALLIANCE EMERGENCY MEDICAL TRANSPORT Total						
70481	PERMANENT SUPPORTIVE HOUSING	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$22,691,075.45	\$23,814,052.37	-\$1,122,976.92
		FEDERAL MEDICAID PAYMENTS Total		\$22,691,075.45	\$23,814,052.37	-\$1,122,976.92
PERMANENT SUPPORTIVE HOUSING Total						
70482	PERMANENT SUPPORTIVE HOUSING-GROUP V111	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$10,573,278.48	\$10,746,349.39	-\$173,070.91
		FEDERAL MEDICAID PAYMENTS Total		\$10,573,278.48	\$10,746,349.39	-\$173,070.91
PERMANENT SUPPORTIVE HOUSING-GROUP V111 Total						
70487	DUAL CHOICE	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$178,549,302.86	\$191,630,573.52	-\$13,081,270.66
		FEDERAL MEDICAID PAYMENTS Total		\$178,549,302.86	\$191,630,573.52	-\$13,081,270.66
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$81,719,786.45	\$84,074,118.92	-\$2,354,332.47
		LOCAL FUND Total		\$81,719,786.45	\$84,074,118.92	-\$2,354,332.47
DUAL CHOICE Total						
70494	HCBS OVERSIGHT & IMPLEMENTATION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	-\$17.14	\$17.14
		FEDERAL MEDICAID PAYMENTS Total		\$0.00	-\$17.14	\$17.14
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$0.00	\$0.00
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	-\$17.14	\$17.14
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00
HCBS OVERSIGHT & IMPLEMENTATION Total						
70499	EMERGENCY MEDICAID GROUP VIII	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$77.35	\$0.00	\$77.35
		FEDERAL MEDICAID PAYMENTS Total		\$77.35	\$0.00	\$77.35
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.59	\$0.00	\$0.59
		LOCAL FUND Total		\$0.59	\$0.00	\$0.59
EMERGENCY MEDICAID GROUP VIII Total						
70500	MCO-ABD	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$30,589,282.46	\$30,589,282.46	\$0.00
		DEDICATED TAXES Total		\$30,589,282.46	\$30,589,282.46	\$0.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$171,086,630.05	\$198,325,360.65	-\$27,238,730.60
		FEDERAL MEDICAID PAYMENTS Total		\$171,086,630.05	\$198,325,360.65	-\$27,238,730.60
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$85,922,311.19	\$84,996,583.34	\$925,727.85
		LOCAL FUND Total		\$85,922,311.19	\$84,996,583.34	\$925,727.85
MCO-ABD Total						
70501	DOULA SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$127,486.43	\$0.00	\$127,486.43
		FEDERAL MEDICAID PAYMENTS Total		\$127,486.43	\$0.00	\$127,486.43
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00
DOULA SERVICES Total						
70503	DDS HCBS ADMINISTRATIVE	LOCAL FUND	CONTINUING FULL TIME - OTHERS	\$53,714.70	\$53,714.70	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$859,524.89	\$706,412.39	\$153,112.50
			FRINGE BENEFITS - CURR PERSONNEL	\$691.92	\$691.92	\$0.00
		LOCAL FUND Total		\$913,931.51	\$760,819.01	\$153,112.50
DDS HCBS ADMINISTRATIVE Total						
70504	HCBS ARPA HCRIA INITIATIVES	LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00
			GOVERNMENT SUBSIDIES & GRANTS	\$131,500.00	\$131,500.00	\$0.00
		LOCAL FUND Total		\$131,500.00	\$131,500.00	\$0.00
		LOCAL FUND Total		\$131,500.00	\$131,500.00	\$0.00
HCBS ARPA HCRIA INITIATIVES Total						
70505	HCBS ARPA LTC IMPROVEMENTS	FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$224,775.00	\$0.00	\$224,775.00
		FEDERAL MEDICAID PAYMENTS Total		\$224,775.00	\$0.00	\$224,775.00
		LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	\$0.00	\$0.00
		LOCAL FUND Total		\$0.00	\$0.00	\$0.00
HCBS ARPA LTC IMPROVEMENTS Total						
PROVIDER SERVICES Total				\$4,198,281,652.68	\$4,206,696,987.04	-\$8,415,334.36
Grand Total				\$4,440,179,423.94	\$4,411,223,736.48	\$28,955,687.46

Department of Health Care Finance (HT0)

FY25 Performance Oversight Hearing

Q9a- FY26 Agency Level

FY 2026 Q1

Appropriated Fund Description	Account Group (Parent Level 1) Description	Sum of Total Budget	Sum of Expenditure	Sum of Available Budget
DEDICATED TAXES	CONTINUING FULL TIME	\$753,062.20	\$125,878.09	\$627,184.11
	CONTINUING FULL TIME - OTHERS	\$74,063.55	\$29,692.83	\$44,370.72
	CONTRACTUAL SERVICES - OTHER	\$151,005.30	\$0.00	\$141,641.66
	FRINGE BENEFITS - CURR PERSONNEL	\$191,893.19	\$32,711.08	\$159,182.11
	GOVERNMENT SUBSIDIES & GRANTS	\$284,756,541.91	\$87,889,129.37	\$196,867,412.54
	OTHER SERVICES & CHARGES	\$9,185.55	\$0.00	\$9,185.55
	PURCHASES EQUIPMENT & MACHINERY	\$2,479.46	\$0.00	\$2,479.46
	SUPPLIES & MATERIALS	\$2,090.00	\$0.00	\$2,090.00
DEDICATED TAXES Total		\$285,940,321.16	\$88,077,411.37	\$197,853,546.15
FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$367,563.00	\$24,215.68	\$343,347.32
	CONTINUING FULL TIME - OTHERS	\$574,215.50	\$77,394.52	\$496,820.98
	CONTRACTUAL SERVICES - OTHER	\$2,842,243.48	\$21,560.00	\$2,532,295.17
	FRINGE BENEFITS - CURR PERSONNEL	\$224,815.50	\$19,574.32	\$205,241.18
	GOVERNMENT SUBSIDIES & GRANTS	\$6,390,938.88	\$197,767.83	\$5,337,639.78
	PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
FEDERAL GRANT FUND - FPR Total		\$10,399,776.36	\$340,512.35	\$8,915,344.43
FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$2,238.55	\$18,020.44	-\$15,781.89
	CONTINUING FULL TIME	\$19,870,489.21	\$4,344,400.44	\$15,526,088.77
	CONTINUING FULL TIME - OTHERS	\$1,080,803.16	\$233,424.40	\$847,378.76
	CONTRACTUAL SERVICES - OTHER	\$111,908,719.14	\$11,176,193.40	\$67,813,923.53
	ENERGY COMM & BLDG RENTALS	\$1,276,356.66	\$200,401.08	\$1,041,996.16
	FRINGE BENEFITS - CURR PERSONNEL	\$4,834,087.89	\$1,096,404.92	\$3,737,682.97
	GOVERNMENT SUBSIDIES & GRANTS	\$4,000,634,219.22	\$688,935,926.40	\$3,308,145,207.00
	OTHER SERVICES & CHARGES	\$2,086,742.65	\$40,034.99	\$2,000,275.71
	OVERTIME PAY	\$0.00	\$5,096.72	-\$5,096.72
	PURCHASES EQUIPMENT & MACHINERY	\$6,401,977.87	\$330,889.38	\$5,057,730.35
	SECURITY SERVICES	\$63,060.82	\$0.00	\$60,675.79
	SUPPLIES & MATERIALS	\$68,449.67	\$809.29	\$67,640.38
	RENTALS EQUIPMENT & OTHER	\$3,240.00	\$0.00	\$3,240.00
FEDERAL MEDICAID PAYMENTS Total		\$4,148,230,384.84	\$706,381,601.46	\$3,404,280,960.81
LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$1,525.24	-\$1,525.24
	CONTINUING FULL TIME	\$18,627,778.31	\$4,266,144.97	\$14,361,633.34
	CONTINUING FULL TIME - OTHERS	\$854,517.46	\$136,293.04	\$718,224.42
	CONTRACTUAL SERVICES - OTHER	\$74,128,023.14	\$4,603,845.78	\$43,026,612.88

	ENERGY COMM & BLDG RENTALS	\$1,361,927.73	\$627,610.50	\$703,047.58
	FRINGE BENEFITS - CURR PERSONNEL	\$4,496,519.78	\$1,073,917.33	\$3,422,602.45
	GOVERNMENT SUBSIDIES & GRANTS	\$946,866,959.59	\$247,472,433.08	\$698,716,745.32
	OTHER SERVICES & CHARGES	\$2,052,404.41	\$69,825.34	\$1,877,307.83
	OVERTIME PAY	\$0.00	\$6,229.33	-\$6,229.33
	P-CARD CLEARING ACCOUNT BUDGET TRACKI	\$0.00	\$2,164.16	-\$2,164.16
	PURCHASES EQUIPMENT & MACHINERY	\$6,188,778.88	\$255,894.95	\$4,766,385.81
	SECURITY SERVICES	\$77,074.34	\$3,589.71	\$35,365.83
	SUPPLIES & MATERIALS	\$52,821.59	\$973.53	\$51,848.06
LOCAL FUND Total		\$1,054,706,805.23	\$258,520,446.96	\$767,669,854.79
SPECIAL PURPOSE REVENUE FUNDS	ADDITIONAL GROSS PAY	\$0.00	\$2,631.82	-\$2,631.82
	CONTINUING FULL TIME	\$1,561,984.19	\$320,427.82	\$1,241,556.37
	CONTINUING FULL TIME - OTHERS	\$109,007.25	\$23,801.15	\$85,206.10
	CONTRACTUAL SERVICES - OTHER	\$3,176,182.06	\$17,215.13	\$2,026,585.10
	FRINGE BENEFITS - CURR PERSONNEL	\$387,670.03	\$75,019.21	\$312,650.82
	GOVERNMENT SUBSIDIES & GRANTS	\$189,021.12	\$0.00	\$189,021.12
	OTHER SERVICES & CHARGES	\$51,617.24	\$0.00	\$51,617.24
	OVERTIME PAY	\$0.00	\$0.00	\$0.00
	PURCHASES EQUIPMENT & MACHINERY	\$1,650.00	\$0.00	\$1,650.00
	SUPPLIES & MATERIALS	\$10,725.00	\$0.00	\$10,725.00
	RENTALS EQUIPMENT & OTHER	\$3,960.00	\$0.00	\$3,960.00
SPECIAL PURPOSE REVENUE FUNDS Total		\$5,491,816.89	\$439,095.13	\$3,920,339.93
Grand Total		\$5,504,769,104.48	\$1,053,759,067.27	\$4,382,640,046.11

Department of Health Care Finance (HT0)
FY25 Performance Oversight Hearing
Q9b- FY26 Program Level

FY 2026 Q1

Program (Parent Level 2) Description	Appropriated Fund Description	Account Group (Parent Level 1) Description	Sum of Total Budget	Sum of Expenditure	Sum of Available Budget
AGENCY FINANCIAL OPERATIONS	DEDICATED TAXES	CONTINUING FULL TIME	\$33,191.95	\$16,060.36	\$17,131.59
		CONTRACTUAL SERVICES - OTHER	\$41,005.30	\$0.00	\$31,641.66
		FRINGE BENEFITS - CURR PERSONNEL	\$7,700.53	\$5,503.37	\$2,197.16
	DEDICATED TAXES Total		\$81,897.78	\$21,563.73	\$50,970.41
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$991,857.58	\$256,380.19	\$735,477.39
		CONTRACTUAL SERVICES - OTHER	\$2,066,124.43	\$0.00	\$867,354.13
		FRINGE BENEFITS - CURR PERSONNEL	\$230,110.96	\$68,297.70	\$161,813.26
		OTHER SERVICES & CHARGES	\$191,750.55	\$0.00	\$191,750.55
		PURCHASES EQUIPMENT & MACHINERY	\$1,350.00	\$0.00	\$1,350.00
		SUPPLIES & MATERIALS	\$2,180.04	\$0.00	\$2,180.04
		FEDERAL MEDICAID PAYMENTS Total		\$3,483,373.56	\$324,677.89
	LOCAL FUND	CONTINUING FULL TIME	\$1,168,369.43	\$297,293.09	\$871,076.34
		CONTRACTUAL SERVICES - OTHER	\$2,484,092.91	\$0.00	\$1,028,292.87
		FRINGE BENEFITS - CURR PERSONNEL	\$273,546.19	\$77,972.20	\$195,573.99
		OTHER SERVICES & CHARGES	\$230,870.89	\$0.00	\$230,870.89
		P-CARD CLEARING ACCOUNT BUDGET TRACKING	\$0.00	\$2,164.16	-\$2,164.16
		PURCHASES EQUIPMENT & MACHINERY	\$1,650.00	\$0.00	\$1,650.00
		SUPPLIES & MATERIALS	\$2,665.39	\$0.00	\$2,665.39
LOCAL FUND Total		\$4,161,194.81	\$377,429.45	\$2,327,965.32	
AGENCY FINANCIAL OPERATIONS Total			\$7,726,466.15	\$723,671.07	\$4,338,861.10
AGENCY MANAGEMENT PROGRAM	DEDICATED TAXES	CONTINUING FULL TIME	\$196,188.85	\$34,478.96	\$161,709.89
		CONTINUING FULL TIME - OTHERS	\$0.00	\$10,973.52	-\$10,973.52
		FRINGE BENEFITS - CURR PERSONNEL	\$45,515.81	\$8,894.97	\$36,620.84
	DEDICATED TAXES Total		\$241,704.66	\$54,347.45	\$187,357.21
	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$367,563.00	\$0.00	\$367,563.00
		FRINGE BENEFITS - CURR PERSONNEL	\$85,274.62	\$0.00	\$85,274.62
	FEDERAL GRANT FUND - FPR Total		\$452,837.62	\$0.00	\$452,837.62
	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$2,238.55	\$16,504.80	-\$14,266.25
		CONTINUING FULL TIME	\$9,206,352.22	\$2,009,330.30	\$7,197,021.92
		CONTINUING FULL TIME - OTHERS	\$703,920.96	\$135,640.29	\$568,280.67
		CONTRACTUAL SERVICES - OTHER	\$18,377,690.49	\$608,581.45	\$10,871,996.13
		ENERGY COMM & BLDG RENTALS	\$535,709.79	\$200,222.47	\$301,527.90
		FRINGE BENEFITS - CURR PERSONNEL	\$2,275,871.86	\$497,983.19	\$1,777,888.67
		OTHER SERVICES & CHARGES	\$537,287.37	\$21,418.93	\$487,837.79
		OVERTIME PAY	\$0.00	\$478.44	-\$478.44
		PURCHASES EQUIPMENT & MACHINERY	\$412,347.78	\$49,932.00	\$208,262.40
		SECURITY SERVICES	\$63,060.82	\$0.00	\$60,675.79
		SUPPLIES & MATERIALS	\$37,792.38	\$623.26	\$37,169.12
		RENTALS EQUIPMENT & OTHER	\$3,240.00	\$0.00	\$3,240.00
	FEDERAL MEDICAID PAYMENTS Total		\$32,155,512.22	\$3,540,715.13	\$21,499,155.70
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$54.31	-\$54.31
		CONTINUING FULL TIME	\$8,444,625.96	\$1,901,895.49	\$6,542,730.47
		CONTINUING FULL TIME - OTHERS	\$660,710.11	\$118,014.20	\$542,695.91
		CONTRACTUAL SERVICES - OTHER	\$10,940,539.58	\$649,309.24	\$5,907,986.42
		ENERGY COMM & BLDG RENTALS	\$654,756.43	\$295,970.98	\$327,515.80
		FRINGE BENEFITS - CURR PERSONNEL	\$2,089,436.65	\$476,215.48	\$1,613,221.17
		OTHER SERVICES & CHARGES	\$600,065.93	\$47,799.13	\$467,942.96

		OVERTIME PAY	\$0.00	\$584.73	-\$584.73
		PURCHASES EQUIPMENT & MACHINERY	\$502,330.41	\$61,028.00	\$252,892.73
		SECURITY SERVICES	\$77,074.34	\$3,589.71	\$35,365.83
		SUPPLIES & MATERIALS	\$34,190.68	\$761.76	\$33,428.92
LOCAL FUND Total			\$24,003,730.09	\$3,555,223.03	\$15,723,141.17
SPECIAL PURPOSE REVENUE FUNDS	ADDITIONAL GROSS PAY	\$0.00	\$2,631.82	-\$2,631.82	
	CONTINUING FULL TIME	\$1,265,941.19	\$258,211.97	\$1,007,729.22	
	CONTINUING FULL TIME - OTHERS	\$109,007.25	\$23,801.15	\$85,206.10	
	CONTRACTUAL SERVICES - OTHER	\$929,928.52	-\$22,399.77	\$805,197.05	
	FRINGE BENEFITS - CURR PERSONNEL	\$318,988.04	\$61,805.70	\$257,182.34	
	OTHER SERVICES & CHARGES	\$51,617.24	\$0.00	\$51,617.24	
	OVERTIME PAY	\$0.00	\$0.00	\$0.00	
	PURCHASES EQUIPMENT & MACHINERY	\$1,650.00	\$0.00	\$1,650.00	
	SUPPLIES & MATERIALS	\$10,725.00	\$0.00	\$10,725.00	
	RENTALS EQUIPMENT & OTHER	\$3,960.00	\$0.00	\$3,960.00	
SPECIAL PURPOSE REVENUE FUNDS Total			\$2,691,817.24	\$324,050.87	\$2,220,635.13
AGENCY MANAGEMENT PROGRAM Total			\$59,545,601.83	\$7,474,336.48	\$40,083,126.83
DC ACCESS SYSTEM	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$1,848,011.00	\$374,863.89	\$1,473,147.11
		CONTRACTUAL SERVICES - OTHER	\$26,438,632.47	\$3,544,292.45	\$17,739,025.14
		ENERGY COMM & BLDG RENTALS	\$740,646.87	\$178.61	\$740,468.26
		FRINGE BENEFITS - CURR PERSONNEL	\$428,826.33	\$92,976.98	\$335,849.35
		OTHER SERVICES & CHARGES	\$1,280,788.52	\$13,509.46	\$1,248,877.76
		OVERTIME PAY	\$0.00	\$0.00	\$0.00
		PURCHASES EQUIPMENT & MACHINERY	\$5,937,219.70	\$280,957.38	\$4,797,057.56
		SUPPLIES & MATERIALS	\$13,275.00	\$186.03	\$13,088.97
	FEDERAL MEDICAID PAYMENTS Total		\$36,687,399.89	\$4,306,964.80	\$26,347,514.15
	LOCAL FUND	CONTINUING FULL TIME	\$1,732,802.75	\$426,731.72	\$1,306,071.03
		CONTRACTUAL SERVICES - OTHER	\$25,723,357.70	\$5,003,539.50	\$13,327,365.42
		ENERGY COMM & BLDG RENTALS	\$707,171.30	\$331,639.52	\$375,531.78
		FRINGE BENEFITS - CURR PERSONNEL	\$402,117.51	\$105,843.75	\$296,273.76
		OTHER SERVICES & CHARGES	\$1,167,677.75	\$15,784.81	\$1,130,945.54
		OVERTIME PAY	\$0.00	\$0.00	\$0.00
		PURCHASES EQUIPMENT & MACHINERY	\$5,668,870.79	\$194,866.95	\$4,495,915.40
		SUPPLIES & MATERIALS	\$12,675.00	\$211.77	\$12,463.23
	LOCAL FUND Total		\$35,414,672.80	\$6,078,618.02	\$20,944,566.16
DC ACCESS SYSTEM Total			\$72,102,072.69	\$10,385,582.82	\$47,292,080.31
ELIGIBILITY & ENROLLMENT	LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
	LOCAL FUND Total		\$0.00	\$0.00	\$0.00
ELIGIBILITY & ENROLLMENT Total			\$0.00	\$0.00	\$0.00
HEALTH CARE DELIVERY MANAGEMENT	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$1,508,381.29	\$317,194.38	\$1,191,186.91
		CONTINUING FULL TIME - OTHERS	\$157,715.10	\$47,180.61	\$110,534.49
		CONTRACTUAL SERVICES - OTHER	\$5,079,754.43	-\$385,823.92	\$1,519,486.26
		FRINGE BENEFITS - CURR PERSONNEL	\$383,610.52	\$85,415.85	\$298,194.67
		OTHER SERVICES & CHARGES	\$39,073.63	\$0.00	\$39,073.63
		PURCHASES EQUIPMENT & MACHINERY	\$37,147.50	\$0.00	\$37,147.50
		SUPPLIES & MATERIALS	\$9,718.25	\$0.00	\$9,718.25
	FEDERAL MEDICAID PAYMENTS Total		\$7,215,400.72	\$63,966.92	\$3,205,341.71
	LOCAL FUND	CONTINUING FULL TIME	\$1,643,738.47	\$359,993.04	\$1,283,745.43
		CONTRACTUAL SERVICES - OTHER	\$5,948,311.26	-\$384,563.90	\$2,334,601.47
		FRINGE BENEFITS - CURR PERSONNEL	\$378,951.55	\$84,517.16	\$294,434.39
		OTHER SERVICES & CHARGES	\$12,006.66	\$0.00	\$12,006.66
		PURCHASES EQUIPMENT & MACHINERY	\$1,402.51	\$0.00	\$1,402.51

		SUPPLIES & MATERIALS	\$877.86	\$0.00	\$877.86
	LOCAL FUND Total		\$7,985,288.31	\$59,946.30	\$3,927,068.32
HEALTH CARE DELIVERY MANAGEMENT Total			\$15,200,689.03	\$123,913.22	\$7,132,410.03
HEALTH CARE OPERATIONS	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$1,395,178.16	\$329,795.86	\$1,065,382.30
		CONTRACTUAL SERVICES - OTHER	\$48,104,858.37	\$6,313,364.80	\$30,123,869.37
		FRINGE BENEFITS - CURR PERSONNEL	\$323,681.35	\$76,313.97	\$247,367.38
		OTHER SERVICES & CHARGES	\$1,575.00	\$0.00	\$1,575.00
		PURCHASES EQUIPMENT & MACHINERY	\$1,350.00	\$0.00	\$1,350.00
		SUPPLIES & MATERIALS	\$585.00	\$0.00	\$585.00
	FEDERAL MEDICAID PAYMENTS Total		\$49,827,227.88	\$6,719,474.63	\$31,440,129.05
	LOCAL FUND	CONTINUING FULL TIME	\$1,237,644.74	\$297,226.56	\$940,418.18
		CONTRACTUAL SERVICES - OTHER	\$17,149,157.37	\$2,319,729.33	\$10,174,120.25
		FRINGE BENEFITS - CURR PERSONNEL	\$287,133.57	\$71,317.42	\$215,816.15
		OTHER SERVICES & CHARGES	\$1,925.00	\$0.00	\$1,925.00
		PURCHASES EQUIPMENT & MACHINERY	\$1,650.00	\$0.00	\$1,650.00
		SUPPLIES & MATERIALS	\$715.00	\$0.00	\$715.00
	LOCAL FUND Total		\$18,678,225.68	\$2,688,273.31	\$11,334,644.58
	SPECIAL PURPOSE REVENUE FUNDS	CONTINUING FULL TIME	\$296,043.00	\$62,215.85	\$233,827.15
		CONTRACTUAL SERVICES - OTHER	\$2,246,253.54	\$39,614.90	\$1,221,388.05
		FRINGE BENEFITS - CURR PERSONNEL	\$68,681.99	\$13,213.51	\$55,468.48
	SPECIAL PURPOSE REVENUE FUNDS Total		\$2,610,978.53	\$115,044.26	\$1,510,683.68
HEALTH CARE OPERATIONS Total			\$71,116,432.09	\$9,522,792.20	\$44,285,457.31
HEALTH CARE POLICY AND RESEARCH	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$142,738.50	\$0.00	\$142,738.50
		FRINGE BENEFITS - CURR PERSONNEL	\$33,829.02	\$0.00	\$33,829.02
	FEDERAL GRANT FUND - FPR Total		\$176,567.52	\$0.00	\$176,567.52
	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$1,086.41	-\$1,086.41
		CONTINUING FULL TIME	\$1,598,938.50	\$377,323.19	\$1,221,615.31
		CONTINUING FULL TIME - OTHERS	\$158,569.65	\$12,922.23	\$145,647.42
		CONTRACTUAL SERVICES - OTHER	\$825,232.05	\$9,803.31	\$397,878.24
		FRINGE BENEFITS - CURR PERSONNEL	\$407,930.44	\$104,407.86	\$303,522.58
		OTHER SERVICES & CHARGES	\$22,205.92	\$0.00	\$22,205.92
		OVERTIME PAY	\$0.00	\$4,036.53	-\$4,036.53
		PURCHASES EQUIPMENT & MACHINERY	\$3,262.78	\$0.00	\$3,262.78
		SUPPLIES & MATERIALS	\$468.00	\$0.00	\$468.00
	FEDERAL MEDICAID PAYMENTS Total		\$3,016,607.34	\$509,579.53	\$2,089,477.31
	LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$1,327.85	-\$1,327.85
		CONTINUING FULL TIME	\$1,954,257.69	\$461,173.20	\$1,493,084.49
		CONTINUING FULL TIME - OTHERS	\$193,807.35	\$15,793.76	\$178,013.59
		CONTRACTUAL SERVICES - OTHER	\$926,116.95	\$11,981.65	\$403,795.75
		FRINGE BENEFITS - CURR PERSONNEL	\$498,581.68	\$127,609.77	\$370,971.91
OTHER SERVICES & CHARGES		\$27,140.57	\$0.00	\$27,140.57	
OVERTIME PAY		\$0.00	\$4,933.55	-\$4,933.55	
PURCHASES EQUIPMENT & MACHINERY		\$3,987.84	\$0.00	\$3,987.84	
SUPPLIES & MATERIALS		\$572.00	\$0.00	\$572.00	
LOCAL FUND Total		\$3,604,464.08	\$622,819.78	\$2,471,304.75	
HEALTH CARE POLICY AND RESEARCH Total			\$6,797,638.94	\$1,132,399.31	\$4,737,349.58
HEALTH CARE REFORM AND INNOVATION	DEDICATED TAXES	CONTINUING FULL TIME	\$523,681.40	\$75,338.77	\$448,342.63
		CONTINUING FULL TIME - OTHERS	\$74,063.55	\$18,719.31	\$55,344.24
		FRINGE BENEFITS - CURR PERSONNEL	\$138,676.85	\$18,312.74	\$120,364.11
		OTHER SERVICES & CHARGES	\$9,185.55	\$0.00	\$9,185.55
		PURCHASES EQUIPMENT & MACHINERY	\$2,479.46	\$0.00	\$2,479.46
		SUPPLIES & MATERIALS	\$2,090.00	\$0.00	\$2,090.00
	DEDICATED TAXES Total		\$750,176.81	\$112,370.82	\$637,805.99

	FEDERAL GRANT FUND - FPR	CONTRACTUAL SERVICES - OTHER	\$995,709.48	\$21,560.00	\$777,469.48
		GOVERNMENT SUBSIDIES & GRANTS	\$1,398,599.55	\$212,500.00	\$1,186,099.55
		PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00
	FEDERAL GRANT FUND - FPR Total		\$2,394,309.03	\$234,060.00	\$1,963,569.03
	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$1,003,637.40	\$153,325.24	\$850,312.16
		CONTINUING FULL TIME - OTHERS	\$60,597.45	\$37,681.27	\$22,916.18
		CONTRACTUAL SERVICES - OTHER	\$2,946,733.08	\$77,560.62	\$2,636,969.73
		FRINGE BENEFITS - CURR PERSONNEL	\$246,902.50	\$40,847.23	\$206,055.27
		GOVERNMENT SUBSIDIES & GRANTS	\$7,065,454.50	\$852,732.78	\$2,659,635.90
		OTHER SERVICES & CHARGES	\$7,515.45	\$0.00	\$7,515.45
		PURCHASES EQUIPMENT & MACHINERY	\$4,278.65	\$0.00	\$4,278.65
		SUPPLIES & MATERIALS	\$3,690.00	\$0.00	\$3,690.00
	FEDERAL MEDICAID PAYMENTS Total		\$11,338,809.03	\$1,162,147.14	\$6,391,373.34
	LOCAL FUND	CONTINUING FULL TIME	\$183,790.20	\$37,229.33	\$146,560.87
		CONTINUING FULL TIME - OTHERS	\$0.00	\$2,485.08	-\$2,485.08
		CONTRACTUAL SERVICES - OTHER	\$1,810,532.73	\$11,477.88	\$1,730,464.58
		FRINGE BENEFITS - CURR PERSONNEL	\$42,639.33	\$9,007.83	\$33,631.50
		GOVERNMENT SUBSIDIES & GRANTS	\$5,340,151.50	\$146,654.21	\$4,515,716.10
		PURCHASES EQUIPMENT & MACHINERY	\$2,750.00	\$0.00	\$2,750.00
		SUPPLIES & MATERIALS	\$220.00	\$0.00	\$220.00
	LOCAL FUND Total		\$7,380,083.76	\$206,854.33	\$6,426,857.97
	HEALTH CARE REFORM AND INNOVATION Total		\$21,863,378.63	\$1,715,432.29	\$15,419,606.33
	LONG TERM CARE PROGRAM	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$0.00	-\$24,215.68
			CONTINUING FULL TIME - OTHERS	\$431,477.00	\$354,082.48
			CONTRACTUAL SERVICES - OTHER	\$1,846,534.00	\$1,754,825.69
			FRINGE BENEFITS - CURR PERSONNEL	\$105,711.86	\$86,137.54
			GOVERNMENT SUBSIDIES & GRANTS	\$4,992,339.33	\$4,151,540.23
		FEDERAL GRANT FUND - FPR Total		\$7,376,062.19	\$6,322,370.26
		FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	-\$429.23
			CONTINUING FULL TIME	\$2,318,133.06	\$1,791,945.67
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$7,979,693.82	\$3,553,925.37
			FRINGE BENEFITS - CURR PERSONNEL	\$537,153.93	\$406,991.79
			OTHER SERVICES & CHARGES	\$6,546.21	\$1,439.61
			OVERTIME PAY	\$0.00	-\$581.75
			PURCHASES EQUIPMENT & MACHINERY	\$5,021.46	\$5,021.46
			SUPPLIES & MATERIALS	\$741.00	\$741.00
		FEDERAL MEDICAID PAYMENTS Total		\$10,847,289.48	\$5,759,053.92
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	-\$143.08
			CONTINUING FULL TIME	\$2,262,549.07	\$1,777,946.53
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00
			CONTRACTUAL SERVICES - OTHER	\$9,145,914.64	\$3,978,040.12
			FRINGE BENEFITS - CURR PERSONNEL	\$524,113.30	\$402,679.58
			OTHER SERVICES & CHARGES	\$12,717.61	\$6,476.21
			OVERTIME PAY	\$0.00	-\$711.05
			PURCHASES EQUIPMENT & MACHINERY	\$6,137.33	\$6,137.33
			SUPPLIES & MATERIALS	\$905.66	\$905.66
		LOCAL FUND Total		\$11,952,337.61	\$6,171,331.30
	LONG TERM CARE PROGRAM Total		\$30,175,689.28	\$3,538,203.18	\$18,252,755.48
	MMIS SYSTEM AND INFRASTRUCTURE	LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	\$4,141,946.00
		LOCAL FUND Total		\$0.00	\$4,141,946.00
	MMIS SYSTEM AND INFRASTRUCTURE Total		\$0.00	-\$4,141,946.00	\$4,141,946.00
	PROGRAM OVERSIGHT	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00

		CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
		FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
	FEDERAL MEDICAID PAYMENTS Total		\$0.00	\$0.00	\$0.00
PROGRAM OVERSIGHT Total			\$0.00	\$0.00	\$0.00
PROVIDER SERVICES	DEDICATED TAXES	CONTRACTUAL SERVICES - OTHER	\$110,000.00	\$0.00	\$110,000.00
		GOVERNMENT SUBSIDIES & GRANTS	\$284,756,541.91	\$87,889,129.37	\$196,867,412.54
	DEDICATED TAXES Total		\$284,866,541.91	\$87,889,129.37	\$196,977,412.54
	FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$90,000.00	-\$13,419.16	\$103,419.16
		GOVERNMENT SUBSIDIES & GRANTS	\$3,993,568,764.72	\$688,083,193.62	\$3,305,485,571.10
	FEDERAL MEDICAID PAYMENTS Total		\$3,993,658,764.72	\$688,069,774.46	\$3,305,588,990.26
	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$941,526,808.09	\$247,325,778.87	\$694,201,029.22
	LOCAL FUND Total		\$941,526,808.09	\$247,325,778.87	\$694,201,029.22
	SPECIAL PURPOSE REVENUE FUNDS	GOVERNMENT SUBSIDIES & GRANTS	\$189,021.12	\$0.00	\$189,021.12
	SPECIAL PURPOSE REVENUE FUNDS Total		\$189,021.12	\$0.00	\$189,021.12
PROVIDER SERVICES Total			\$5,220,241,135.84	\$1,023,284,682.70	\$4,196,956,453.14
Grand Total			\$5,504,769,104.48	\$1,053,759,067.27	\$4,382,640,046.11

Department of Health Care Finance (HT0)
FY25 Performance Oversight Hearing
Q9c- FY26 Amount Budgeted and Actual Spend

FY 2026 Q1

Program (Parent Level 2) Description	Cost Center	Cost Center Description	Appropriated Fund Description	Account Group (Parent Level 1) Description	Sum of Total Budget	Sum of Expenditure	Sum of Available Budget	
AGENCY FINANCIAL OPERATIONS	10001	BUDGET DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$324,246.71	\$79,859.76	\$244,386.95	
				FRINGE BENEFITS - CURR PERSONNEL	\$75,225.22	\$22,039.59	\$53,185.63	
			FEDERAL MEDICAID PAYMENTS Total		\$399,471.93	\$101,899.35	\$297,572.58	
			LOCAL FUND	CONTINUING FULL TIME	\$396,301.54	\$97,606.67	\$298,694.87	
				FRINGE BENEFITS - CURR PERSONNEL	\$91,941.97	\$26,938.10	\$65,003.87	
			LOCAL FUND Total	\$488,243.51	\$124,544.77	\$363,698.74		
		BUDGET DIVISION Total		\$887,715.44	\$226,444.12	\$661,271.32		
		10002	ACCOUNTING DIVISION	DEDICATED TAXES	CONTINUING FULL TIME	\$33,191.95	\$16,060.36	\$17,131.59
					CONTRACTUAL SERVICES - OTHER	\$41,005.30	\$0.00	\$31,641.66
					FRINGE BENEFITS - CURR PERSONNEL	\$7,700.53	\$5,503.37	\$2,197.16
	DEDICATED TAXES Total			\$81,897.78	\$21,563.73	\$50,970.41		
	FEDERAL MEDICAID PAYMENTS			CONTINUING FULL TIME	\$531,620.87	\$141,060.05	\$390,560.82	
				CONTRACTUAL SERVICES - OTHER	\$2,066,124.43	\$0.00	\$867,354.13	
				FRINGE BENEFITS - CURR PERSONNEL	\$123,336.06	\$40,693.09	\$82,642.97	
				OTHER SERVICES & CHARGES	\$182,144.37	\$0.00	\$182,144.37	
	FEDERAL MEDICAID PAYMENTS Total			\$2,903,225.73	\$181,753.14	\$1,522,702.29		
	LOCAL FUND		CONTINUING FULL TIME	\$605,857.89	\$156,345.92	\$449,511.97		
			CONTRACTUAL SERVICES - OTHER	\$2,484,092.91	\$0.00	\$1,028,292.87		
			FRINGE BENEFITS - CURR PERSONNEL	\$143,043.50	\$44,232.36	\$98,811.14		
			OTHER SERVICES & CHARGES	\$222,620.89	\$0.00	\$222,620.89		
			LOCAL FUND Total	\$3,455,615.19	\$200,578.28	\$1,799,236.87		
	ACCOUNTING DIVISION Total		\$6,440,738.70	\$403,895.15	\$3,372,909.57			
	10003		ACFO DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$135,990.00	\$35,460.38	\$100,529.62
					FRINGE BENEFITS - CURR PERSONNEL	\$31,549.68	\$5,565.02	\$25,984.66
				FEDERAL MEDICAID PAYMENTS Total		\$167,539.68	\$41,025.40	\$126,514.28
		LOCAL FUND		CONTINUING FULL TIME	\$166,210.00	\$43,340.50	\$122,869.50	
			FRINGE BENEFITS - CURR PERSONNEL	\$38,560.72	\$6,801.74	\$31,758.98		
		LOCAL FUND Total		\$204,770.72	\$50,142.24	\$154,628.48		
		ACFO DIVISION Total		\$372,310.40	\$91,167.64	\$281,142.76		
	10070	BUDGET DIVISION - HSSC	FEDERAL MEDICAID PAYMENTS	PURCHASES EQUIPMENT & MACHINERY	\$675.00	\$0.00	\$675.00	
			FEDERAL MEDICAID PAYMENTS Total		\$675.00	\$0.00	\$675.00	
			LOCAL FUND	PURCHASES EQUIPMENT & MACHINERY	\$825.00	\$0.00	\$825.00	
			LOCAL FUND Total		\$825.00	\$0.00	\$825.00	
			BUDGET DIVISION - HSSC Total		\$1,500.00	\$0.00	\$1,500.00	
	10071	ACCOUNTING DIVISION - HSSC	FEDERAL MEDICAID PAYMENTS	OTHER SERVICES & CHARGES	\$9,606.18	\$0.00	\$9,606.18	
				SUPPLIES & MATERIALS	\$2,180.04	\$0.00	\$2,180.04	
			FEDERAL MEDICAID PAYMENTS Total		\$11,786.22	\$0.00	\$11,786.22	
			LOCAL FUND	OTHER SERVICES & CHARGES	\$8,250.00	\$0.00	\$8,250.00	
				SUPPLIES & MATERIALS	\$2,665.39	\$0.00	\$2,665.39	
			LOCAL FUND Total		\$10,915.39	\$0.00	\$10,915.39	
	ACCOUNTING DIVISION - HSSC Total		\$22,701.61	\$0.00	\$22,701.61			
	10072	ACFO DIVISION - HSSC	FEDERAL MEDICAID PAYMENTS	PURCHASES EQUIPMENT & MACHINERY	\$675.00	\$0.00	\$675.00	
			FEDERAL MEDICAID PAYMENTS Total		\$675.00	\$0.00	\$675.00	
			LOCAL FUND	PURCHASES EQUIPMENT & MACHINERY	\$825.00	\$0.00	\$825.00	
			LOCAL FUND Total		\$825.00	\$0.00	\$825.00	
			ACFO DIVISION - HSSC Total		\$1,500.00	\$0.00	\$1,500.00	
	10086	P-CARD CLEARING	LOCAL FUND	P-CARD CLEARING ACCOUNT BUDGET TRACKI	\$0.00	\$2,164.16	-\$2,164.16	
			LOCAL FUND Total		\$0.00	\$2,164.16	-\$2,164.16	
			P-CARD CLEARING Total		\$0.00	\$2,164.16	-\$2,164.16	
			AGENCY FINANCIAL OPERATIONS Total		\$7,726,466.15	\$723,671.07	\$4,338,861.10	

AGENCY MANAGEMENT PROGRAM	70156	INVESTIGATION AND COMPLIANCE DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$373,708.80	\$80,949.18	\$292,759.62
				CONTRACTUAL SERVICES - OTHER	\$10,440.00	-\$629.01	\$0.00
				FRINGE BENEFITS - CURR PERSONNEL	\$87,070.35	\$13,427.12	\$73,643.23
			FEDERAL MEDICAID PAYMENTS Total		\$471,219.15	\$93,747.29	\$366,402.85
			LOCAL FUND	CONTINUING FULL TIME	\$455,182.61	\$98,937.91	\$356,244.70
				CONTRACTUAL SERVICES - OTHER	\$12,760.00	-\$768.79	\$0.00
				FRINGE BENEFITS - CURR PERSONNEL	\$106,063.90	\$16,410.89	\$89,653.01
			LOCAL FUND Total		\$574,006.51	\$114,580.01	\$445,897.71
			INVESTIGATION AND COMPLIANCE DIVISION Total		\$1,045,225.66	\$208,327.30	\$812,300.56
	70157	SURVEILLANCE AND UTILIZATION DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$771,596.40	\$172,313.95	\$599,282.45
				CONTINUING FULL TIME - OTHERS	\$166,007.60	\$20,370.73	\$145,636.87
				CONTRACTUAL SERVICES - OTHER	\$469,861.50	\$2,264.06	\$456,277.12
				FRINGE BENEFITS - CURR PERSONNEL	\$220,718.52	\$56,026.60	\$164,691.92
			FEDERAL MEDICAID PAYMENTS Total		\$1,628,184.02	\$250,975.34	\$1,365,888.36
			LOCAL FUND	CONTINUING FULL TIME	\$590,350.27	\$143,745.92	\$446,604.35
				CONTINUING FULL TIME - OTHERS	\$202,898.18	\$24,897.53	\$178,000.65
				CONTRACTUAL SERVICES - OTHER	\$179,620.50	\$2,767.19	\$163,017.37
				FRINGE BENEFITS - CURR PERSONNEL	\$187,937.91	\$49,643.84	\$138,294.07
			LOCAL FUND Total		\$1,160,806.86	\$221,054.48	\$925,916.44
			SURVEILLANCE AND UTILIZATION DIVISION Total		\$2,788,990.88	\$472,029.82	\$2,291,804.80
	70158	PROGRAM INTEGRITY SUPPORT DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$588,054.98	\$155,652.75	\$432,402.23
				CONTINUING FULL TIME - OTHERS	\$30,322.35	\$0.00	\$30,322.35
				FRINGE BENEFITS - CURR PERSONNEL	\$143,250.80	\$32,581.99	\$110,668.81
				OTHER SERVICES & CHARGES	\$11,858.64	\$0.00	\$11,858.64
				PURCHASES EQUIPMENT & MACHINERY	\$4,050.00	\$0.00	\$4,050.00
				SUPPLIES & MATERIALS	\$1,092.57	\$0.00	\$1,092.57
			FEDERAL MEDICAID PAYMENTS Total		\$778,629.34	\$188,234.74	\$590,394.60
			LOCAL FUND	CONTINUING FULL TIME	\$718,733.86	\$190,242.74	\$528,491.12
				CONTINUING FULL TIME - OTHERS	\$37,060.65	\$0.00	\$37,060.65
				FRINGE BENEFITS - CURR PERSONNEL	\$175,084.30	\$39,823.26	\$135,261.04
				OTHER SERVICES & CHARGES	\$14,493.90	\$0.00	\$14,493.90
				PURCHASES EQUIPMENT & MACHINERY	\$4,950.00	\$0.00	\$4,950.00
				SUPPLIES & MATERIALS	\$1,335.37	\$0.00	\$1,335.37
			LOCAL FUND Total		\$951,658.08	\$230,066.00	\$721,592.08
			PROGRAM INTEGRITY SUPPORT DIVISION Total		\$1,730,287.42	\$418,300.74	\$1,311,986.68
	70274	OFFICE OF THE OMBUDSMAN - HT0	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$7,113.32	-\$7,113.32
				CONTINUING FULL TIME	\$1,315,298.77	\$228,279.32	\$1,087,019.45
				CONTINUING FULL TIME - OTHERS	\$89,187.75	\$19,473.64	\$69,714.11
				CONTRACTUAL SERVICES - OTHER	\$765,972.32	-\$26,626.08	\$672,218.28
				FRINGE BENEFITS - CURR PERSONNEL	\$325,840.89	\$55,214.09	\$270,626.80
				OTHER SERVICES & CHARGES	\$42,232.29	\$0.00	\$42,232.29
				OVERTIME PAY	\$0.00	\$0.00	\$0.00
				PURCHASES EQUIPMENT & MACHINERY	\$3,037.50	\$0.00	\$3,037.50
				SUPPLIES & MATERIALS	\$8,775.00	\$0.00	\$8,775.00
				RENTALS EQUIPMENT & OTHER	\$3,240.00	\$0.00	\$3,240.00
			FEDERAL MEDICAID PAYMENTS Total		\$2,553,584.52	\$283,454.29	\$2,149,750.11
			LOCAL FUND	CONTINUING FULL TIME	\$77,112.19	\$0.00	\$77,112.19
				FRINGE BENEFITS - CURR PERSONNEL	\$17,890.04	\$0.00	\$17,890.04
				PURCHASES EQUIPMENT & MACHINERY	\$2,062.50	\$0.00	\$2,062.50
			LOCAL FUND Total		\$97,064.73	\$0.00	\$97,064.73
			SPECIAL PURPOSE REVENUE FUNDS	ADDITIONAL GROSS PAY	\$0.00	\$2,631.82	-\$2,631.82
				CONTINUING FULL TIME	\$1,265,941.19	\$258,211.97	\$1,007,729.22
				CONTINUING FULL TIME - OTHERS	\$109,007.25	\$23,801.15	\$85,206.10
				CONTRACTUAL SERVICES - OTHER	\$929,928.52	-\$22,399.77	\$805,197.05
				FRINGE BENEFITS - CURR PERSONNEL	\$318,988.04	\$61,805.70	\$257,182.34
				OTHER SERVICES & CHARGES	\$51,617.24	\$0.00	\$51,617.24
				OVERTIME PAY	\$0.00	\$0.00	\$0.00
				PURCHASES EQUIPMENT & MACHINERY	\$1,650.00	\$0.00	\$1,650.00
				SUPPLIES & MATERIALS	\$10,725.00	\$0.00	\$10,725.00
				RENTALS EQUIPMENT & OTHER	\$3,960.00	\$0.00	\$3,960.00
			SPECIAL PURPOSE REVENUE FUNDS Total		\$2,691,817.24	\$324,050.87	\$2,220,635.13
			OFFICE OF THE OMBUDSMAN - HT0 Total		\$5,342,466.49	\$607,505.16	\$4,467,449.97

70275	OFFICE OF THE DIRECTOR'S ADMINISTRATIVE OFFICE	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$402,812.66	\$56,302.67	\$346,509.99
			CONTINUING FULL TIME - OTHERS	\$114,249.38	\$39,990.66	\$74,258.72
			CONTRACTUAL SERVICES - OTHER	\$36,717.75	\$0.00	\$36,717.75
			FRINGE BENEFITS - CURR PERSONNEL	\$114,085.31	\$19,467.43	\$94,617.88
			OTHER SERVICES & CHARGES	\$9,697.60	\$0.00	\$9,697.60
			OVERTIME PAY	\$0.00	\$80.75	-\$80.75
			PURCHASES EQUIPMENT & MACHINERY	\$2,250.00	\$0.00	\$2,250.00
			SUPPLIES & MATERIALS	\$2,255.64	\$0.00	\$2,255.64
			FEDERAL MEDICAID PAYMENTS Total	\$682,068.34	\$115,841.51	\$566,226.83
		LOCAL FUND	CONTINUING FULL TIME	\$492,326.60	\$68,814.47	\$423,512.13
			CONTINUING FULL TIME - OTHERS	\$139,638.13	\$48,877.32	\$90,760.81
			CONTRACTUAL SERVICES - OTHER	\$219,877.25	\$0.00	\$219,877.25
			FRINGE BENEFITS - CURR PERSONNEL	\$139,437.62	\$23,793.51	\$115,644.11
			OTHER SERVICES & CHARGES	\$11,852.49	\$0.00	\$11,852.49
			OVERTIME PAY	\$0.00	\$98.69	-\$98.69
			PURCHASES EQUIPMENT & MACHINERY	\$2,750.00	\$0.00	\$2,750.00
			SUPPLIES & MATERIALS	\$2,756.89	\$0.00	\$2,756.89
			LOCAL FUND Total	\$1,008,638.98	\$141,583.99	\$867,054.99
		OFFICE OF THE DIRECTOR'S ADMINISTRATIVE OFFICE Total		\$1,690,707.32	\$257,425.50	\$1,433,281.82
70277	COMPLIANCE DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$16,200.00	\$0.00	\$16,200.00
		FEDERAL MEDICAID PAYMENTS Total		\$16,200.00	\$0.00	\$16,200.00
		LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$19,800.00	\$0.00	\$19,800.00
		LOCAL FUND Total		\$19,800.00	\$0.00	\$19,800.00
		COMPLIANCE DIVISION - HT0 Total		\$36,000.00	\$0.00	\$36,000.00
70278	SUPPORT SERVICES DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$221,412.20	\$58,450.18	\$162,962.02
			CONTINUING FULL TIME - OTHERS	\$25,605.37	\$6,673.68	\$18,931.69
			CONTRACTUAL SERVICES - OTHER	\$674,668.93	\$54,524.24	\$165,380.61
			ENERGY COMM & BLDG RENTALS	\$535,709.79	\$200,222.47	\$301,527.90
			FRINGE BENEFITS - CURR PERSONNEL	\$59,084.61	\$13,599.48	\$45,485.13
			OTHER SERVICES & CHARGES	\$127,202.54	\$0.00	\$127,202.54
			OVERTIME PAY	\$0.00	\$134.72	-\$134.72
			SECURITY SERVICES	\$63,060.82	\$0.00	\$60,675.79
			FEDERAL MEDICAID PAYMENTS Total	\$1,706,744.26	\$333,604.77	\$882,030.96
		LOCAL FUND	CONTINUING FULL TIME	\$270,614.92	\$71,439.13	\$199,175.79
			CONTINUING FULL TIME - OTHERS	\$31,295.45	\$8,156.69	\$23,138.76
			CONTRACTUAL SERVICES - OTHER	\$824,595.37	\$66,640.72	\$202,131.86
			ENERGY COMM & BLDG RENTALS	\$654,756.43	\$295,970.98	\$327,515.80
			FRINGE BENEFITS - CURR PERSONNEL	\$72,214.52	\$16,621.44	\$55,593.08
			OTHER SERVICES & CHARGES	\$155,469.76	\$1,697.79	\$153,771.97
			OVERTIME PAY	\$0.00	\$164.64	-\$164.64
			SECURITY SERVICES	\$77,074.34	\$3,589.71	\$35,365.83
			LOCAL FUND Total	\$2,086,020.79	\$464,281.10	\$996,528.45
		SUPPORT SERVICES DIVISION - HT0 Total		\$3,792,765.05	\$797,885.87	\$1,878,559.41
70279	HUMAN RESOURCES DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$302,243.85	\$71,642.86	\$230,600.99
			CONTINUING FULL TIME - OTHERS	\$56,727.00	\$6,673.69	\$50,053.31
			CONTRACTUAL SERVICES - OTHER	\$234,378.54	\$0.00	\$234,378.54
			FRINGE BENEFITS - CURR PERSONNEL	\$83,281.24	\$17,901.55	\$65,379.69
			PURCHASES EQUIPMENT & MACHINERY	\$6,750.00	\$0.00	\$6,750.00
		FEDERAL MEDICAID PAYMENTS Total		\$683,380.63	\$96,218.10	\$587,162.53
		LOCAL FUND	CONTINUING FULL TIME	\$369,409.15	\$87,563.54	\$281,845.61
			CONTINUING FULL TIME - OTHERS	\$69,333.00	\$8,156.68	\$61,176.32
			CONTRACTUAL SERVICES - OTHER	\$11,462.66	\$0.00	\$11,462.66
			FRINGE BENEFITS - CURR PERSONNEL	\$101,788.17	\$21,879.71	\$79,908.46
			PURCHASES EQUIPMENT & MACHINERY	\$8,250.00	\$0.00	\$8,250.00
		LOCAL FUND Total		\$560,242.98	\$117,599.93	\$442,643.05
		HUMAN RESOURCES DIVISION - HT0 Total		\$1,243,623.61	\$213,818.03	\$1,029,805.58

70280	INFORMATION TECHNOLOGY DIVISION - HT0	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$898,499.67	\$225,165.36	\$673,334.31
			CONTRACTUAL SERVICES - OTHER	\$6,209,902.12	\$868,814.67	\$1,638,713.39
			FRINGE BENEFITS - CURR PERSONNEL	\$208,336.10	\$56,723.64	\$151,612.46
			OTHER SERVICES & CHARGES	\$171,087.91	\$20,114.22	\$125,319.04
			OVERTIME PAY	\$0.00	\$262.97	-\$262.97
			PURCHASES EQUIPMENT & MACHINERY	\$385,997.52	\$49,932.00	\$181,912.14
			SUPPLIES & MATERIALS	\$6,274.43	\$0.00	\$6,274.43
			FEDERAL MEDICAID PAYMENTS Total	\$7,880,097.75	\$1,221,012.86	\$2,776,902.80
		LOCAL FUND	CONTINUING FULL TIME	\$1,098,166.27	\$275,202.66	\$822,963.61
			CONTRACTUAL SERVICES - OTHER	\$3,865,922.60	\$527,204.52	\$1,043,809.64
			FRINGE BENEFITS - CURR PERSONNEL	\$254,633.03	\$69,328.75	\$185,304.28
			OTHER SERVICES & CHARGES	\$209,107.45	\$44,506.69	\$83,180.92
			OVERTIME PAY	\$0.00	\$321.40	-\$321.40
			PURCHASES EQUIPMENT & MACHINERY	\$471,774.54	\$61,028.00	\$222,336.86
			SUPPLIES & MATERIALS	\$7,218.75	\$0.00	\$7,218.75
			LOCAL FUND Total	\$5,906,822.64	\$977,592.02	\$2,364,492.66
		INFORMATION TECHNOLOGY DIVISION - HT0 Total		\$13,786,920.39	\$2,198,604.88	\$5,141,395.46
70281	CONTRACTS DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$684,469.61	\$176,936.40	\$507,533.21
			CONTRACTUAL SERVICES - OTHER	\$4,500.00	\$0.00	\$4,500.00
			FRINGE BENEFITS - CURR PERSONNEL	\$152,032.46	\$40,786.40	\$111,246.06
			FEDERAL MEDICAID PAYMENTS Total	\$841,002.07	\$217,722.80	\$623,279.27
		LOCAL FUND	CONTINUING FULL TIME	\$836,573.97	\$216,255.67	\$620,318.30
			CONTRACTUAL SERVICES - OTHER	\$5,500.00	\$0.00	\$5,500.00
			FRINGE BENEFITS - CURR PERSONNEL	\$185,817.44	\$49,849.68	\$135,967.76
			LOCAL FUND Total	\$1,027,891.41	\$266,105.35	\$761,786.06
		CONTRACTS DIVISION Total		\$1,868,893.48	\$483,828.15	\$1,385,065.33
70282	OFFICE OF THE GENERAL COUNSEL - HT0	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$2,238.55	\$9,347.04	-\$7,108.49
			CONTINUING FULL TIME	\$511,537.17	\$112,088.34	\$399,448.83
			CONTINUING FULL TIME - OTHERS	\$74,152.21	\$10,631.00	\$63,521.21
			CONTRACTUAL SERVICES - OTHER	\$13,500.00	\$0.00	\$13,500.00
			FRINGE BENEFITS - CURR PERSONNEL	\$133,428.29	\$26,708.81	\$106,719.48
			OTHER SERVICES & CHARGES	\$7,467.00	\$0.00	\$7,467.00
			PURCHASES EQUIPMENT & MACHINERY	\$1,125.00	\$0.00	\$1,125.00
			SUPPLIES & MATERIALS	\$675.00	\$0.00	\$675.00
			FEDERAL MEDICAID PAYMENTS Total	\$744,123.22	\$158,775.19	\$585,348.03
		LOCAL FUND	CONTINUING FULL TIME	\$579,639.42	\$115,923.88	\$463,715.54
			CONTRACTUAL SERVICES - OTHER	\$16,500.00	\$0.00	\$16,500.00
			FRINGE BENEFITS - CURR PERSONNEL	\$134,476.34	\$25,848.88	\$108,627.46
			OTHER SERVICES & CHARGES	\$4,125.00	\$0.00	\$4,125.00
			PURCHASES EQUIPMENT & MACHINERY	\$1,375.00	\$0.00	\$1,375.00
			LOCAL FUND Total	\$736,115.76	\$141,772.76	\$594,343.00
		OFFICE OF THE GENERAL COUNSEL - HT0 Total		\$1,480,238.98	\$300,547.95	\$1,179,691.03
70489	CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$410,773.63	\$94,620.41	\$316,153.22
			CONTRACTUAL SERVICES - OTHER	\$52,632.00	\$5,472.24	\$18,316.70
			FRINGE BENEFITS - CURR PERSONNEL	\$80,918.97	\$21,980.87	\$58,938.10
			OTHER SERVICES & CHARGES	\$98,130.38	\$1,304.71	\$94,449.67
			PURCHASES EQUIPMENT & MACHINERY	\$4,637.76	\$0.00	\$4,637.76
			SUPPLIES & MATERIALS	\$13,477.21	\$623.26	\$12,853.95
			FEDERAL MEDICAID PAYMENTS Total	\$660,569.95	\$124,001.49	\$505,349.40
		LOCAL FUND	CONTINUING FULL TIME	\$502,056.66	\$115,647.25	\$386,409.41
			CONTRACTUAL SERVICES - OTHER	\$64,328.00	-\$60,592.76	\$51,027.61
			FRINGE BENEFITS - CURR PERSONNEL	\$98,900.99	\$26,865.36	\$72,035.63
			OTHER SERVICES & CHARGES	\$119,937.17	\$1,594.65	\$115,438.52
			PURCHASES EQUIPMENT & MACHINERY	\$5,668.37	\$0.00	\$5,668.37
			SUPPLIES & MATERIALS	\$16,472.14	\$761.76	\$15,710.38
			LOCAL FUND Total	\$807,363.33	\$84,276.26	\$646,289.92
		CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS Total		\$1,467,933.28	\$208,277.75	\$1,151,639.32
70528	OFFICE OF CHIEF MEDICAL OFFICER	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$134,264.00	\$0.00	\$134,264.00
			FRINGE BENEFITS - CURR PERSONNEL	\$31,149.25	\$0.00	\$31,149.25
		FEDERAL GRANT FUND - FPR Total		\$165,413.25	\$0.00	\$165,413.25
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$1,012,740.18	\$220,762.11	\$791,978.07
			CONTRACTUAL SERVICES - OTHER	\$7,266,290.77	-\$307,826.28	\$5,238,217.43
			FRINGE BENEFITS - CURR PERSONNEL	\$234,955.72	\$44,918.55	\$190,037.17
			FEDERAL MEDICAID PAYMENTS Total	\$8,513,986.67	-\$42,145.62	\$6,220,232.67
		LOCAL FUND	CONTINUING FULL TIME	\$488,320.87	\$117,286.07	\$371,034.80

		CONTRACTUAL SERVICES - OTHER	\$3,279,740.72	\$98,673.48	\$2,033,933.42
		FRINGE BENEFITS - CURR PERSONNEL	\$113,290.44	\$24,475.89	\$88,814.55
		LOCAL FUND Total	\$3,881,352.03	\$240,435.44	\$2,493,782.77
	OFFICE OF CHIEF MEDICAL OFFICER Total		\$12,560,751.95	\$198,289.82	\$8,879,428.69

70530	SENIOR DEPUTY DIRECTOR MEDICAID DIRE	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$173,413.74	\$50,517.69	\$122,896.05	
			CONTINUING FULL TIME - OTHERS	\$20,186.55	\$0.00	\$20,186.55	
			CONTRACTUAL SERVICES - OTHER	\$688,187.43	\$0.00	\$688,187.43	
			FRINGE BENEFITS - CURR PERSONNEL	\$44,446.94	\$11,519.26	\$32,927.68	
			OTHER SERVICES & CHARGES	\$8,672.08	\$0.00	\$8,672.08	
			PURCHASES EQUIPMENT & MACHINERY	\$2,250.00	\$0.00	\$2,250.00	
			SUPPLIES & MATERIALS	\$2,255.64	\$0.00	\$2,255.64	
			FEDERAL MEDICAID PAYMENTS Total	\$939,412.38	\$62,036.95	\$877,375.43	
			LOCAL FUND	CONTINUING FULL TIME	\$291,071.47	\$61,743.89	\$229,327.58
				CONTINUING FULL TIME - OTHERS	\$24,672.45	\$0.00	\$24,672.45
				CONTRACTUAL SERVICES - OTHER	\$241,117.98	\$0.00	\$241,117.98
				FRINGE BENEFITS - CURR PERSONNEL	\$72,680.18	\$14,079.35	\$58,600.83
				OTHER SERVICES & CHARGES	\$10,599.22	\$0.00	\$10,599.22
				PURCHASES EQUIPMENT & MACHINERY	\$2,750.00	\$0.00	\$2,750.00
				SUPPLIES & MATERIALS	\$2,756.89	\$0.00	\$2,756.89
				LOCAL FUND Total	\$645,648.19	\$75,823.24	\$569,824.95
			SENIOR DEPUTY DIRECTOR MEDICAID DIRECTOR DASH ADMISTRATIVE FUNCTIONS Total			\$1,585,060.57	\$137,860.19
70536	ANALYTIC REPORTING DIVISION	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$134,264.00	\$0.00	\$134,264.00	
			FRINGE BENEFITS - CURR PERSONNEL	\$31,149.25	\$0.00	\$31,149.25	
		FEDERAL GRANT FUND - FPR Total	\$165,413.25	\$0.00	\$165,413.25		
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$270,099.51	\$43,466.27	\$226,633.24	
			CONTRACTUAL SERVICES - OTHER	\$435,652.93	\$0.00	\$427,724.17	
			FRINGE BENEFITS - CURR PERSONNEL	\$63,023.92	\$10,985.01	\$52,038.91	
			FEDERAL MEDICAID PAYMENTS Total	\$768,776.36	\$54,451.28	\$706,396.32	
		LOCAL FUND	CONTINUING FULL TIME	\$330,121.62	\$53,125.39	\$276,996.23	
			CONTRACTUAL SERVICES - OTHER	\$367,464.70	\$0.00	\$357,773.98	
			FRINGE BENEFITS - CURR PERSONNEL	\$77,029.22	\$13,426.28	\$63,602.94	
			LOCAL FUND Total	\$774,615.54	\$66,551.67	\$698,373.15	
		ANALYTIC REPORTING DIVISION Total			\$1,708,805.15	\$121,002.95	\$1,570,182.72
70537	RESEARCH AND DEVELOPMENT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$44.44	-\$44.44	
			CONTINUING FULL TIME	\$262,460.62	\$50,949.79	\$211,510.83	
			CONTINUING FULL TIME - OTHERS	\$29,378.25	\$0.00	\$29,378.25	
			FRINGE BENEFITS - CURR PERSONNEL	\$68,154.91	\$8,892.44	\$59,262.47	
			FEDERAL MEDICAID PAYMENTS Total	\$359,993.78	\$59,886.67	\$300,107.11	
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$54.31	-\$54.31	
			CONTINUING FULL TIME	\$320,785.20	\$62,272.06	\$258,513.14	
			CONTINUING FULL TIME - OTHERS	\$35,906.75	\$0.00	\$35,906.75	
			FRINGE BENEFITS - CURR PERSONNEL	\$83,300.45	\$10,868.65	\$72,431.80	
			LOCAL FUND Total	\$439,992.40	\$73,195.02	\$366,797.38	
			RESEARCH AND DEVELOPMENT DIVISION Total			\$799,986.18	\$133,081.69
		70538	SENIOR DEPUTY DIRECTOR FINANCE ADMIN	DEDICATED TAXES	CONTINUING FULL TIME	\$57,750.55	\$0.00
CONTINUING FULL TIME - OTHERS	\$0.00				\$10,973.52	-\$10,973.52	
FRINGE BENEFITS - CURR PERSONNEL	\$13,398.13				\$1,413.88	\$11,984.25	
DEDICATED TAXES Total	\$71,148.68				\$12,387.40	\$58,761.28	
FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME			\$99,035.00	\$0.00	\$99,035.00	
	FRINGE BENEFITS - CURR PERSONNEL			\$22,976.12	\$0.00	\$22,976.12	
FEDERAL GRANT FUND - FPR Total	\$122,011.12			\$0.00	\$122,011.12		
FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME			\$269,256.66	\$46,930.62	\$222,326.04	
	CONTINUING FULL TIME - OTHERS			\$16,380.00	\$11,028.77	\$5,351.23	
	CONTRACTUAL SERVICES - OTHER			\$1,498,786.20	\$12,587.61	\$1,261,664.71	
	FRINGE BENEFITS - CURR PERSONNEL			\$67,072.84	\$13,606.97	\$53,465.87	
	OTHER SERVICES & CHARGES			\$55,083.96	\$0.00	\$55,083.96	
	PURCHASES EQUIPMENT & MACHINERY			\$2,250.00	\$0.00	\$2,250.00	
	SUPPLIES & MATERIALS			\$2,255.64	\$0.00	\$2,255.64	
	FEDERAL MEDICAID PAYMENTS Total			\$1,911,085.30	\$84,153.97	\$1,602,397.45	
LOCAL FUND	CONTINUING FULL TIME			\$271,340.92	\$57,359.55	\$213,981.37	
	CONTINUING FULL TIME - OTHERS			\$20,020.00	\$2,506.06	\$17,513.94	
	CONTRACTUAL SERVICES - OTHER			\$1,831,849.80	\$15,384.88	\$1,542,034.65	
	FRINGE BENEFITS - CURR PERSONNEL			\$68,579.79	\$15,216.82	\$53,362.97	
	OTHER SERVICES & CHARGES			\$67,324.84	\$0.00	\$67,324.84	
	PURCHASES EQUIPMENT & MACHINERY			\$2,750.00	\$0.00	\$2,750.00	
	SUPPLIES & MATERIALS			\$2,756.89	\$0.00	\$2,756.89	
	LOCAL FUND Total			\$2,264,622.24	\$90,467.31	\$1,899,724.66	
SPECIAL PURPOSE REVENUE FUNDS	CONTINUING FULL TIME - OTHERS			\$0.00	\$0.00	\$0.00	
	FRINGE BENEFITS - CURR PERSONNEL			\$0.00	\$0.00	\$0.00	

			SPECIAL PURPOSE REVENUE FUNDS Total	\$0.00	\$0.00	\$0.00
			SENIOR DEPUTY DIRECTOR FINANCE ADMINISTRATIVE FUNCTIONS Total	\$4,368,867.34	\$187,008.68	\$3,682,894.51
70539	OFFICE OF RATES REIMBURSEMENT AND FINANCIAL ANALYSIS	DEDICATED TAXES	CONTINUING FULL TIME	\$138,438.30	\$34,478.96	\$103,959.34
			FRINGE BENEFITS - CURR PERSONNEL	\$32,117.68	\$7,481.09	\$24,636.59
		DEDICATED TAXES Total		\$170,555.98	\$41,960.05	\$128,595.93
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$737,973.77	\$164,302.40	\$573,671.37
			CONTINUING FULL TIME - OTHERS	\$81,724.50	\$20,798.12	\$60,926.38
			FRINGE BENEFITS - CURR PERSONNEL	\$190,169.99	\$53,642.98	\$136,527.01
		FEDERAL MEDICAID PAYMENTS Total		\$1,009,868.26	\$238,743.50	\$771,124.76
		LOCAL FUND	CONTINUING FULL TIME	\$752,819.96	\$166,335.36	\$586,484.60
			CONTINUING FULL TIME - OTHERS	\$99,885.50	\$25,419.92	\$74,465.58
			FRINGE BENEFITS - CURR PERSONNEL	\$200,312.31	\$58,083.17	\$142,229.14
		LOCAL FUND Total		\$1,053,017.77	\$249,838.45	\$803,179.32
		OFFICE OF RATES REIMBURSEMENT AND FINANCIAL ANALYSIS Total		\$2,233,442.01	\$530,542.00	\$1,702,900.01
71000	DARA SUPPORT DIVISION	FEDERAL MEDICAID PAYMENTS	OTHER SERVICES & CHARGES	\$5,854.97	\$0.00	\$5,854.97
			SUPPLIES & MATERIALS	\$731.25	\$0.00	\$731.25
		FEDERAL MEDICAID PAYMENTS Total		\$6,586.22	\$0.00	\$6,586.22
		LOCAL FUND	OTHER SERVICES & CHARGES	\$7,156.10	\$0.00	\$7,156.10
			SUPPLIES & MATERIALS	\$893.75	\$0.00	\$893.75
		LOCAL FUND Total		\$8,049.85	\$0.00	\$8,049.85
		DARA SUPPORT DIVISION Total		\$14,636.07	\$0.00	\$14,636.07
AGENCY MANAGEMENT PROGRAM Total				\$59,545,601.83	\$7,474,336.48	\$40,083,126.83

DC ACCESS SYSTEM	70152	DCAS - PROGRAM MANAGEMENT DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$288,685.78	\$65,747.32	\$222,938.46	
				CONTRACTUAL SERVICES - OTHER	\$580,135.20	\$142,159.61	\$292,464.64	
				FRINGE BENEFITS - CURR PERSONNEL	\$66,975.11	\$13,334.75	\$53,640.36	
				FEDERAL MEDICAID PAYMENTS Total	\$935,796.09	\$221,241.68	\$569,043.46	
				LOCAL FUND	CONTINUING FULL TIME	\$275,637.86	\$74,844.42	\$200,793.44
					CONTRACTUAL SERVICES - OTHER	\$553,914.41	\$165,739.12	\$222,530.77
					FRINGE BENEFITS - CURR PERSONNEL	\$62,631.77	\$15,179.40	\$47,452.37
					OTHER SERVICES & CHARGES	\$0.00	-\$2,112.50	\$2,112.50
					LOCAL FUND Total	\$892,184.04	\$253,650.44	\$472,889.08
				DCAS - PROGRAM MANAGEMENT DIVISION Total				\$1,827,980.13
	70153	PROJECT MANAGEMENT DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$338,237.49	\$52,567.33	\$285,670.16	
				CONTRACTUAL SERVICES - OTHER	\$1,481,192.05	\$361,118.32	\$1,044,338.80	
				ENERGY COMM & BLDG RENTALS	\$3,135.50	\$178.61	\$2,956.89	
				FRINGE BENEFITS - CURR PERSONNEL	\$78,471.09	\$15,542.45	\$62,928.64	
				OTHER SERVICES & CHARGES	\$11,090.21	\$0.00	\$11,090.21	
				OVERTIME PAY	\$0.00	\$0.00	\$0.00	
				PURCHASES EQUIPMENT & MACHINERY	\$89,629.10	\$0.00	\$89,629.10	
				SUPPLIES & MATERIALS	\$13,275.00	\$186.03	\$13,088.97	
				FEDERAL MEDICAID PAYMENTS Total	\$2,015,030.44	\$429,592.74	\$1,509,702.77	
				LOCAL FUND	CONTINUING FULL TIME	\$295,179.21	\$59,840.72	\$235,338.49
	CONTRACTUAL SERVICES - OTHER	\$1,430,103.84	\$423,650.79		\$902,220.21			
	ENERGY COMM & BLDG RENTALS	\$2,993.78	\$170.54		\$2,823.24			
	FRINGE BENEFITS - CURR PERSONNEL	\$69,797.79	\$17,693.55		\$52,104.24			
	OTHER SERVICES & CHARGES	\$11,349.63	\$0.00		\$11,349.63			
	OVERTIME PAY	\$0.00	\$0.00		\$0.00			
	PURCHASES EQUIPMENT & MACHINERY	\$85,578.07	\$0.00		\$85,578.07			
	SUPPLIES & MATERIALS	\$12,675.00	\$211.77		\$12,463.23			
	LOCAL FUND Total	\$1,907,677.32	\$501,567.37		\$1,301,877.11			
	PROJECT MANAGEMENT DIVISION Total				\$3,922,707.76	\$931,160.11	\$2,811,579.88	
	70154	ORGANIZATIONAL CHANGE DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$377,122.29	\$76,883.94	\$300,238.35	
				CONTRACTUAL SERVICES - OTHER	\$4,976,582.73	\$428,219.51	\$3,162,073.04	
				ENERGY COMM & BLDG RENTALS	\$737,511.37	\$0.00	\$737,511.37	
				FRINGE BENEFITS - CURR PERSONNEL	\$87,580.16	\$17,704.51	\$69,875.65	
				PURCHASES EQUIPMENT & MACHINERY	\$132,750.00	\$0.00	\$132,750.00	
				FEDERAL MEDICAID PAYMENTS Total	\$6,311,546.55	\$522,807.96	\$4,402,448.41	
				LOCAL FUND	CONTINUING FULL TIME	\$356,165.55	\$87,522.09	\$268,643.46
					CONTRACTUAL SERVICES - OTHER	\$4,840,652.44	\$824,249.64	\$954,583.29
					ENERGY COMM & BLDG RENTALS	\$704,177.52	\$331,468.98	\$372,708.54
					FRINGE BENEFITS - CURR PERSONNEL	\$82,737.67	\$20,154.51	\$62,583.16
	PURCHASES EQUIPMENT & MACHINERY	\$126,750.00	\$0.00		\$126,750.00			
	LOCAL FUND Total	\$6,110,483.18	\$1,263,395.22		\$1,785,268.45			
	ORGANIZATIONAL CHANGE DIVISION Total				\$12,422,029.73	\$1,786,203.18	\$6,187,716.86	
	70155	DCAS INFORMATION TECHNOLOGY MANAC	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$490,419.43	\$98,841.70	\$391,577.73	
				CONTRACTUAL SERVICES - OTHER	\$19,400,722.49	\$2,612,795.01	\$13,240,148.66	
				FRINGE BENEFITS - CURR PERSONNEL	\$113,777.29	\$25,627.21	\$88,150.08	
				OTHER SERVICES & CHARGES	\$1,269,698.31	\$13,509.46	\$1,237,787.55	
				PURCHASES EQUIPMENT & MACHINERY	\$5,714,840.60	\$280,957.38	\$4,574,678.46	
				FEDERAL MEDICAID PAYMENTS Total	\$26,989,458.12	\$3,031,730.76	\$19,532,342.48	
				LOCAL FUND	CONTINUING FULL TIME	\$468,253.61	\$112,517.80	\$355,735.81
					CONTRACTUAL SERVICES - OTHER	\$18,898,687.01	\$3,589,899.95	\$11,248,031.15
					FRINGE BENEFITS - CURR PERSONNEL	\$108,634.83	\$29,173.73	\$79,461.10
					OTHER SERVICES & CHARGES	\$1,156,328.12	\$17,897.31	\$1,117,483.41
	PURCHASES EQUIPMENT & MACHINERY	\$5,456,542.72	\$194,866.95		\$4,283,587.33			
	LOCAL FUND Total	\$26,088,446.29	\$3,944,355.74		\$17,084,298.80			
	DCAS INFORMATION TECHNOLOGY MANAGEMENT DIVISION Total				\$53,077,904.41	\$6,976,086.50	\$36,616,641.28	
	70535	DCAS HHS FUNCTIONAL DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$353,546.01	\$80,823.60	\$272,722.41	
				FRINGE BENEFITS - CURR PERSONNEL	\$82,022.68	\$20,768.06	\$61,254.62	
			FEDERAL MEDICAID PAYMENTS Total		\$435,568.69	\$101,591.66	\$333,977.03	
			LOCAL FUND	CONTINUING FULL TIME	\$337,566.52	\$92,006.69	\$245,559.83	
				FRINGE BENEFITS - CURR PERSONNEL	\$78,315.45	\$23,642.56	\$54,672.89	
			LOCAL FUND Total		\$415,881.97	\$115,649.25	\$300,232.72	
	DCAS HHS FUNCTIONAL DIVISION Total				\$851,450.66	\$217,240.91	\$634,209.75	
	DC ACCESS SYSTEM Total					\$72,102,072.69	\$10,385,582.82	\$47,292,080.31
	ELIGIBILITY & ENROLLMENT	70280	INFORMATION TECHNOLOGY DIVISION - HT	LOCAL FUND	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00
				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00	

		LOCAL FUND Total	\$0.00	\$0.00	\$0.00
		INFORMATION TECHNOLOGY DIVISION - HT0 Total	\$0.00	\$0.00	\$0.00
ELIGIBILITY & ENROLLMENT Total			\$0.00	\$0.00	\$0.00

HEALTH CARE DELIVERY MANAGEM	70159	HEALTH CARE DELIVERY MGT SUPPORT SE	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$547,438.71	\$129,223.37	\$418,215.34			
				FRINGE BENEFITS - CURR PERSONNEL	\$119,908.24	\$29,678.36	\$90,229.88			
				OTHER SERVICES & CHARGES	\$9,823.63	\$0.00	\$9,823.63			
				PURCHASES EQUIPMENT & MACHINERY	\$1,147.50	\$0.00	\$1,147.50			
				SUPPLIES & MATERIALS	\$718.25	\$0.00	\$718.25			
				FEDERAL MEDICAID PAYMENTS Total		\$679,036.33	\$158,901.73	\$520,134.60		
				LOCAL FUND	CONTINUING FULL TIME	\$669,091.76	\$157,940.35	\$511,151.41		
					FRINGE BENEFITS - CURR PERSONNEL	\$146,554.51	\$36,274.11	\$110,280.40		
					OTHER SERVICES & CHARGES	\$12,006.66	\$0.00	\$12,006.66		
					PURCHASES EQUIPMENT & MACHINERY	\$1,402.51	\$0.00	\$1,402.51		
			SUPPLIES & MATERIALS		\$877.86	\$0.00	\$877.86			
			LOCAL FUND Total		\$829,933.30	\$194,214.46	\$635,718.84			
			HEALTH CARE DELIVERY MGT SUPPORT SERVICES DIVISION Total				\$1,508,969.63	\$353,116.19	\$1,155,853.44	
			70160	DIVISION OF MANAGED CARE	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$319,958.49	\$59,390.38	\$260,568.11	
						CONTRACTUAL SERVICES - OTHER	\$3,842,735.17	\$98,905.45	\$1,335,117.13	
						FRINGE BENEFITS - CURR PERSONNEL	\$78,637.93	\$14,685.20	\$63,952.73	
						FEDERAL MEDICAID PAYMENTS Total		\$4,241,331.59	\$172,981.03	\$1,659,637.97
						LOCAL FUND	CONTINUING FULL TIME	\$391,060.38	\$72,588.62	\$318,471.76
					CONTRACTUAL SERVICES - OTHER		\$4,696,676.33	\$251,918.02	\$1,011,059.16	
					FRINGE BENEFITS - CURR PERSONNEL		\$96,113.02	\$17,948.30	\$78,164.72	
					LOCAL FUND Total		\$5,183,849.73	\$342,454.94	\$1,407,695.64	
	DIVISION OF MANAGED CARE Total				\$9,425,181.32	\$515,435.97	\$3,067,333.61			
	70161	DIVISION OF CLINICIANS, PHARMACY, & AC			FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$496,403.32	\$0.00	
					FEDERAL MEDICAID PAYMENTS Total		\$0.00	-\$496,403.32	\$0.00	
					LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$640,373.24	\$474,905.58	
					LOCAL FUND Total		\$0.00	-\$640,373.24	\$474,905.58	
					DIVISION OF CLINICIANS, PHARMACY, & ACUTE PROVIDER SERVICES Total				\$0.00	-\$1,136,776.56
	70162	DIVISION OF QUALITY AND HEALTH OUTCO			FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$258,641.21	\$49,660.92	\$208,980.29	
			CONTRACTUAL SERVICES - OTHER	\$866,357.07		\$0.00	\$13,907.33			
			FRINGE BENEFITS - CURR PERSONNEL	\$60,734.57		\$12,041.04	\$48,693.53			
			FEDERAL MEDICAID PAYMENTS Total			\$1,185,732.85	\$61,701.96	\$271,581.15		
			LOCAL FUND	CONTINUING FULL TIME		\$316,117.02	\$60,696.73	\$255,420.29		
				CONTRACTUAL SERVICES - OTHER	\$1,058,880.86	\$0.00	\$774,730.93			
				FRINGE BENEFITS - CURR PERSONNEL	\$74,231.14	\$14,716.67	\$59,514.47			
				LOCAL FUND Total		\$1,449,229.02	\$75,413.40	\$1,089,665.69		
			DIVISION OF QUALITY AND HEALTH OUTCOMES Total				\$2,634,961.87	\$137,115.36	\$1,361,246.84	
			70163	DIVISION OF CHILDREN'S HEALTH SERVICES	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$382,342.88	\$78,919.71	\$303,423.17	
	CONTINUING FULL TIME - OTHERS	\$157,715.10				\$47,180.61	\$110,534.49			
	CONTRACTUAL SERVICES - OTHER	\$370,662.19				\$11,673.95	\$170,461.80			
	FRINGE BENEFITS - CURR PERSONNEL	\$124,329.78				\$29,011.25	\$95,318.53			
	OTHER SERVICES & CHARGES	\$29,250.00				\$0.00	\$29,250.00			
	PURCHASES EQUIPMENT & MACHINERY	\$36,000.00				\$0.00	\$36,000.00			
	SUPPLIES & MATERIALS	\$9,000.00				\$0.00	\$9,000.00			
	FEDERAL MEDICAID PAYMENTS Total					\$1,109,299.95	\$166,785.52	\$753,987.99		
	LOCAL FUND	CONTINUING FULL TIME				\$267,469.31	\$68,767.34	\$198,701.97		
		CONTRACTUAL SERVICES - OTHER				\$192,754.07	\$3,891.32	\$73,905.80		
		FRINGE BENEFITS - CURR PERSONNEL			\$62,052.88	\$15,578.08	\$46,474.80			
		OTHER SERVICES & CHARGES			\$0.00	\$0.00	\$0.00			
	LOCAL FUND Total				\$522,276.26	\$88,236.74	\$319,082.57			
	DIVISION OF CHILDREN'S HEALTH SERVICES Total				\$1,631,576.21	\$255,022.26	\$1,073,070.56			
	HEALTH CARE DELIVERY MANAGEMENT Total					\$15,200,689.03	\$123,913.22	\$7,132,410.03		
	HEALTH CARE OPERATIONS	70260			HEALTH CARE OPERATIONS SUPPORT OFFIC	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$173,574.49	\$43,870.40	\$129,704.09
							FRINGE BENEFITS - CURR PERSONNEL	\$40,269.29	\$8,844.23	\$31,425.06
							OTHER SERVICES & CHARGES	\$1,575.00	\$0.00	\$1,575.00
							PURCHASES EQUIPMENT & MACHINERY	\$1,350.00	\$0.00	\$1,350.00
			SUPPLIES & MATERIALS	\$585.00			\$0.00	\$585.00		
			FEDERAL MEDICAID PAYMENTS Total				\$217,353.78	\$52,714.63	\$164,639.15	
			LOCAL FUND	CONTINUING FULL TIME			\$212,146.59	\$53,619.28	\$158,527.31	
				FRINGE BENEFITS - CURR PERSONNEL			\$49,218.01	\$10,809.31	\$38,408.70	
				OTHER SERVICES & CHARGES			\$1,925.00	\$0.00	\$1,925.00	
				PURCHASES EQUIPMENT & MACHINERY			\$1,650.00	\$0.00	\$1,650.00	
				SUPPLIES & MATERIALS		\$715.00	\$0.00	\$715.00		
			LOCAL FUND Total			\$265,654.60	\$64,428.59	\$201,226.01		
			HEALTH CARE OPERATIONS SUPPORT OFFICE Total				\$483,008.38	\$117,143.22	\$365,865.16	
			70261	DIVISION OF CLAIMS MANAGEMENT		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$799,212.60	\$190,950.93	\$608,261.67

			CONTRACTUAL SERVICES - OTHER	\$45,733,966.82	\$6,155,189.80	\$28,746,033.47		
			FRINGE BENEFITS - CURR PERSONNEL	\$185,417.33	\$45,503.15	\$139,914.18		
		FEDERAL MEDICAID PAYMENTS Total			\$46,718,596.75	\$6,391,643.88	\$29,494,209.32	
		LOCAL FUND	CONTINUING FULL TIME	\$509,242.40	\$127,527.22	\$381,715.18		
			CONTRACTUAL SERVICES - OTHER	\$14,251,401.02	\$2,126,404.33	\$8,490,098.58		
			FRINGE BENEFITS - CURR PERSONNEL	\$118,144.24	\$33,659.51	\$84,484.73		
		LOCAL FUND Total			\$14,878,787.66	\$2,287,591.06	\$8,956,298.49	
		SPECIAL PURPOSE REVENUE FUNDS	CONTINUING FULL TIME	\$296,043.00	\$62,215.85	\$233,827.15		
			CONTRACTUAL SERVICES - OTHER	\$2,246,253.54	\$39,614.90	\$1,221,388.05		
			FRINGE BENEFITS - CURR PERSONNEL	\$68,681.99	\$13,213.51	\$55,468.48		
		SPECIAL PURPOSE REVENUE FUNDS Total			\$2,610,978.53	\$115,044.26	\$1,510,683.68	
	DIVISION OF CLAIMS MANAGEMENT Total			\$64,208,362.94	\$8,794,279.20	\$39,961,191.49		
	70262	DIVISION OF PUBLIC AND PRIVATE PROVIDER SERVICES	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$422,391.07	\$94,974.53	\$327,416.54	
				CONTRACTUAL SERVICES - OTHER	\$2,370,891.55	\$158,175.00	\$1,377,835.90	
				FRINGE BENEFITS - CURR PERSONNEL	\$97,994.73	\$21,966.59	\$76,028.14	
			FEDERAL MEDICAID PAYMENTS Total			\$2,891,277.35	\$275,116.12	\$1,781,280.58
			LOCAL FUND	CONTINUING FULL TIME	\$516,255.75	\$116,080.06	\$400,175.69	
				CONTRACTUAL SERVICES - OTHER	\$2,897,756.35	\$193,325.00	\$1,684,021.67	
				FRINGE BENEFITS - CURR PERSONNEL	\$119,771.32	\$26,848.60	\$92,922.72	
			LOCAL FUND Total			\$3,533,783.42	\$336,253.66	\$2,177,120.08
	DIVISION OF PUBLIC AND PRIVATE PROVIDER SERVICES Total			\$6,425,060.77	\$611,369.78	\$3,958,400.66		
HEALTH CARE OPERATIONS Total			\$71,116,432.09	\$9,522,792.20	\$44,285,457.31			

HEALTH CARE POLICY AND RESEARCH	70263	HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$173,377.74	\$45,181.44	\$128,196.30	
				CONTINUING FULL TIME - OTHERS	\$30,322.35	\$0.00	\$30,322.35	
			CONTRACTUAL SERVICES - OTHER	FRINGE BENEFITS - CURR PERSONNEL	\$299,295.00	\$7,944.81	\$273,878.04	
				OTHER SERVICES & CHARGES	\$47,045.67	\$10,312.29	\$36,733.38	
			PURCHASES EQUIPMENT & MACHINERY	PURCHASES EQUIPMENT & MACHINERY	\$22,205.92	\$0.00	\$22,205.92	
				SUPPLIES & MATERIALS	\$3,262.78	\$0.00	\$3,262.78	
			FEDERAL MEDICAID PAYMENTS Total		\$468.00	\$0.00	\$468.00	
					\$575,977.46	\$63,438.54	\$495,066.77	
			LOCAL FUND	CONTINUING FULL TIME	\$211,905.66	\$55,221.76	\$156,683.90	
				CONTINUING FULL TIME - OTHERS	\$37,060.65	\$0.00	\$37,060.65	
			CONTRACTUAL SERVICES - OTHER	FRINGE BENEFITS - CURR PERSONNEL	\$283,305.00	\$9,710.15	\$252,239.95	
				OTHER SERVICES & CHARGES	\$57,500.26	\$12,603.66	\$44,896.60	
			PURCHASES EQUIPMENT & MACHINERY	PURCHASES EQUIPMENT & MACHINERY	\$27,140.57	\$0.00	\$27,140.57	
				SUPPLIES & MATERIALS	\$3,987.84	\$0.00	\$3,987.84	
			LOCAL FUND Total		\$572.00	\$0.00	\$572.00	
					\$621,471.98	\$77,535.57	\$522,581.51	
			HEALTH CARE POLICY & RESEARCH SUPPORT SERVICES DIVISION Total			\$1,197,449.44	\$140,974.11	\$1,017,648.28
	70264	DIVISION OF REGULATIONS & POLICY MANAGEMENT	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$273,595.79	\$55,583.52	\$218,012.27	
				CONTINUING FULL TIME - OTHERS	\$99,382.50	\$9,387.40	\$89,995.10	
			FRINGE BENEFITS - CURR PERSONNEL	FRINGE BENEFITS - CURR PERSONNEL	\$86,530.97	\$17,312.12	\$69,218.85	
					\$459,509.26	\$82,283.04	\$377,226.22	
			LOCAL FUND	CONTINUING FULL TIME	\$334,394.85	\$67,935.47	\$266,459.38	
				CONTINUING FULL TIME - OTHERS	\$121,467.50	\$11,473.43	\$109,994.07	
			FRINGE BENEFITS - CURR PERSONNEL	FRINGE BENEFITS - CURR PERSONNEL	\$105,760.06	\$21,159.13	\$84,600.93	
					\$561,622.41	\$100,568.03	\$461,054.38	
			DIVISION OF REGULATIONS & POLICY MANAGEMENT Total			\$1,021,131.67	\$182,851.07	\$838,280.60
			70266	DIVISION OF ELIGIBILITY POLICY	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$366,279.75	\$72,300.07
	CONTRACTUAL SERVICES - OTHER	\$525,937.05				\$1,858.50	\$124,000.20	
	FRINGE BENEFITS - CURR PERSONNEL	FRINGE BENEFITS - CURR PERSONNEL			\$84,976.90	\$22,160.36	\$62,816.54	
					\$977,193.70	\$96,318.93	\$480,796.42	
	LOCAL FUND	CONTINUING FULL TIME			\$447,675.25	\$88,366.95	\$359,308.30	
		CONTRACTUAL SERVICES - OTHER			\$642,811.95	\$2,271.50	\$151,555.80	
	FRINGE BENEFITS - CURR PERSONNEL	FRINGE BENEFITS - CURR PERSONNEL			\$103,860.65	\$27,085.08	\$76,775.57	
					\$1,194,347.85	\$117,723.53	\$587,639.67	
	DIVISION OF ELIGIBILITY POLICY Total					\$2,171,541.55	\$214,042.46	\$1,068,436.09
	70534	ELIGIBILITY DETERMINATION			FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME - OTHERS	\$142,738.50	\$0.00
			FRINGE BENEFITS - CURR PERSONNEL	\$33,829.02		\$0.00	\$33,829.02	
			FEDERAL GRANT FUND - FPR Total			\$176,567.52	\$0.00	\$176,567.52
			FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$1,086.41	-\$1,086.41	
				CONTINUING FULL TIME	\$785,685.22	\$204,258.16	\$581,427.06	
			CONTINUING FULL TIME - OTHERS	FRINGE BENEFITS - CURR PERSONNEL	\$28,864.80	\$3,534.83	\$25,329.97	
				FRINGE BENEFITS - CURR PERSONNEL	\$189,376.90	\$54,623.09	\$134,753.81	
			OVERTIME PAY	OVERTIME PAY	\$0.00	\$4,036.53	-\$4,036.53	
					\$1,003,926.92	\$267,539.02	\$736,387.90	
			LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$1,327.85	-\$1,327.85	
				CONTINUING FULL TIME	\$960,281.93	\$249,649.02	\$710,632.91	
			CONTINUING FULL TIME - OTHERS	FRINGE BENEFITS - CURR PERSONNEL	\$35,279.20	\$4,320.33	\$30,958.87	
				FRINGE BENEFITS - CURR PERSONNEL	\$231,460.71	\$66,761.90	\$164,698.81	
			OVERTIME PAY	OVERTIME PAY	\$0.00	\$4,933.55	-\$4,933.55	
					\$1,227,021.84	\$326,992.65	\$900,029.19	
			LOCAL FUND Total			\$2,407,516.28	\$594,531.67	\$1,812,984.61
	ELIGIBILITY DETERMINATION Total			\$6,797,638.94	\$1,132,399.31	\$4,737,349.58		
	HEALTH CARE POLICY AND RESEARCH Total							
	HEALTH CARE REFORM AND INNOVATION	70267	AFFORDABLE CARE REFORM AND GRANTS	DEDICATED TAXES	CONTINUING FULL TIME	\$229,845.55	\$20,240.29	\$209,605.26
					CONTINUING FULL TIME - OTHERS	\$74,063.55	\$18,719.31	\$55,344.24
				FRINGE BENEFITS - CURR PERSONNEL	FRINGE BENEFITS - CURR PERSONNEL	\$70,506.92	\$9,782.72	\$60,724.20
					\$374,416.02	\$48,742.32	\$325,673.70	
FEDERAL GRANT FUND - FPR				CONTRACTUAL SERVICES - OTHER	\$995,709.48	\$21,560.00	\$777,469.48	
				GOVERNMENT SUBSIDIES & GRANTS	\$1,398,599.55	\$212,500.00	\$1,186,099.55	
PURCHASES EQUIPMENT & MACHINERY				PURCHASES EQUIPMENT & MACHINERY	\$0.00	\$0.00	\$0.00	
					\$2,394,309.03	\$234,060.00	\$1,963,569.03	
FEDERAL MEDICAID PAYMENTS				CONTINUING FULL TIME	\$188,055.45	\$16,560.13	\$171,495.32	
				CONTINUING FULL TIME - OTHERS	\$60,597.45	\$15,315.77	\$45,281.68	
CONTRACTUAL SERVICES - OTHER				FRINGE BENEFITS - CURR PERSONNEL	\$1,048,906.08	\$2,574.00	\$1,007,821.08	
				FRINGE BENEFITS - CURR PERSONNEL	\$57,687.48	\$8,003.93	\$49,683.55	
GOVERNMENT SUBSIDIES & GRANTS				GOVERNMENT SUBSIDIES & GRANTS	\$1,350,000.00	\$0.00	\$1,350,000.00	
					\$1,350,000.00	\$0.00	\$1,350,000.00	

			FEDERAL MEDICAID PAYMENTS Total		\$2,705,246.46	\$42,453.83	\$2,624,281.63
			LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$1,281,996.33	\$3,146.00	\$1,231,781.33
				GOVERNMENT SUBSIDIES & GRANTS	\$3,275,000.00	\$0.00	\$3,275,000.00
			LOCAL FUND Total		\$4,556,996.33	\$3,146.00	\$4,506,781.33
			AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION Total		\$10,030,967.84	\$328,402.15	\$9,420,305.69
70268	HIT/HIE PROJECT MANAGEMENT DIVISION	DEDICATED TAXES		CONTINUING FULL TIME	\$76,498.40	\$19,334.69	\$57,163.71
				CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
				FRINGE BENEFITS - CURR PERSONNEL	\$17,747.63	\$3,947.25	\$13,800.38
		DEDICATED TAXES Total			\$94,246.03	\$23,281.94	\$70,964.09
		FEDERAL MEDICAID PAYMENTS		CONTINUING FULL TIME	\$601,407.60	\$93,152.79	\$508,254.81
				CONTINUING FULL TIME - OTHERS	\$0.00	\$22,365.50	-\$22,365.50
				CONTRACTUAL SERVICES - OTHER	\$1,897,827.00	\$74,986.62	\$1,629,148.65
				FRINGE BENEFITS - CURR PERSONNEL	\$139,526.57	\$26,287.33	\$113,239.24
				GOVERNMENT SUBSIDIES & GRANTS	\$5,715,454.50	\$852,732.78	\$1,309,635.90
				PURCHASES EQUIPMENT & MACHINERY	\$2,250.00	\$0.00	\$2,250.00
				SUPPLIES & MATERIALS	\$1,980.00	\$0.00	\$1,980.00
		FEDERAL MEDICAID PAYMENTS Total			\$8,358,445.67	\$1,069,525.02	\$3,542,143.10
		LOCAL FUND		CONTINUING FULL TIME	\$139,359.00	\$19,689.19	\$119,669.81
				CONTINUING FULL TIME - OTHERS	\$0.00	\$2,485.08	-\$2,485.08
				CONTRACTUAL SERVICES - OTHER	\$528,536.40	\$8,331.88	\$498,683.25
				FRINGE BENEFITS - CURR PERSONNEL	\$32,331.29	\$5,577.67	\$26,753.62
				GOVERNMENT SUBSIDIES & GRANTS	\$2,065,151.50	\$146,654.21	\$1,240,716.10
				PURCHASES EQUIPMENT & MACHINERY	\$2,750.00	\$0.00	\$2,750.00
				SUPPLIES & MATERIALS	\$220.00	\$0.00	\$220.00
		LOCAL FUND Total			\$2,768,348.19	\$182,738.03	\$1,886,307.70
		HIT/HIE PROJECT MANAGEMENT DIVISION Total			\$11,221,039.89	\$1,275,544.99	\$5,499,414.89
70269	HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES DIVISION	DEDICATED TAXES		CONTINUING FULL TIME	\$217,337.45	\$35,763.79	\$181,573.66
				FRINGE BENEFITS - CURR PERSONNEL	\$50,422.30	\$4,582.77	\$45,839.53
				OTHER SERVICES & CHARGES	\$9,185.55	\$0.00	\$9,185.55
				PURCHASES EQUIPMENT & MACHINERY	\$2,479.46	\$0.00	\$2,479.46
				SUPPLIES & MATERIALS	\$2,090.00	\$0.00	\$2,090.00
		DEDICATED TAXES Total			\$281,514.76	\$40,346.56	\$241,168.20
		FEDERAL MEDICAID PAYMENTS		CONTINUING FULL TIME	\$214,174.35	\$43,612.32	\$170,562.03
				FRINGE BENEFITS - CURR PERSONNEL	\$49,688.45	\$6,555.97	\$43,132.48
				OTHER SERVICES & CHARGES	\$7,515.45	\$0.00	\$7,515.45
				PURCHASES EQUIPMENT & MACHINERY	\$2,028.65	\$0.00	\$2,028.65
				SUPPLIES & MATERIALS	\$1,710.00	\$0.00	\$1,710.00
		FEDERAL MEDICAID PAYMENTS Total			\$275,116.90	\$50,168.29	\$224,948.61
		LOCAL FUND		CONTINUING FULL TIME	\$44,431.20	\$17,540.14	\$26,891.06
				FRINGE BENEFITS - CURR PERSONNEL	\$10,308.04	\$3,430.16	\$6,877.88
		LOCAL FUND Total			\$54,739.24	\$20,970.30	\$33,768.94
		HEALTH CARE REFORM AND INNOVATIVE SUPPORT SERVICES DIVISION Total			\$611,370.90	\$111,485.15	\$499,885.75
HEALTH CARE REFORM AND INNOVATION Total					\$21,863,378.63	\$1,715,432.29	\$15,419,606.33

LONG TERM CARE PROGRAM	70270	LONG TERM CARE SUPPORT SERVICES DIVISION	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$283,984.20	\$45,071.39	\$238,912.81	
				CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00	
				FRINGE BENEFITS - CURR PERSONNEL	\$65,884.34	\$8,898.38	\$56,985.96	
				OTHER SERVICES & CHARGES	\$6,546.21	\$5,106.60	\$1,439.61	
				PURCHASES EQUIPMENT & MACHINERY	\$5,021.46	\$0.00	\$5,021.46	
				SUPPLIES & MATERIALS	\$741.00	\$0.00	\$741.00	
				FEDERAL MEDICAID PAYMENTS Total		\$362,177.21	\$59,076.37	\$303,100.84
				LOCAL FUND	CONTINUING FULL TIME	\$347,091.80	\$55,087.29	\$292,004.51
					CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00
					FRINGE BENEFITS - CURR PERSONNEL	\$80,525.29	\$10,875.82	\$69,649.47
OTHER SERVICES & CHARGES	\$12,167.61	\$6,241.40	\$5,926.21					
PURCHASES EQUIPMENT & MACHINERY	\$6,137.33	\$0.00	\$6,137.33					
SUPPLIES & MATERIALS	\$905.66	\$0.00	\$905.66					
LOCAL FUND Total		\$446,827.69	\$72,204.51	\$374,623.18				
LONG TERM CARE SUPPORT SERVICES DIVISION Total			\$809,004.90	\$131,280.88	\$677,724.02			
70271	LONG TERM CARE OVERSIGHT DIVISION	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$0.00	\$16,479.45	-\$16,479.45		
			CONTINUING FULL TIME - OTHERS	\$431,477.00	\$77,394.52	\$354,082.48		
			FRINGE BENEFITS - CURR PERSONNEL	\$105,711.86	\$18,597.73	\$87,114.13		
		FEDERAL GRANT FUND - FPR Total		\$537,188.86	\$112,471.70	\$424,717.16		
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$783,714.19	\$217,209.42	\$566,504.77		
			FRINGE BENEFITS - CURR PERSONNEL	\$182,410.79	\$49,157.21	\$133,253.58		
			OVERTIME PAY	\$0.00	-\$0.01	\$0.01		
		FEDERAL MEDICAID PAYMENTS Total		\$966,124.98	\$266,366.62	\$699,758.36		
		LOCAL FUND	CONTINUING FULL TIME	\$621,952.90	\$176,331.68	\$445,621.22		
			FRINGE BENEFITS - CURR PERSONNEL	\$145,013.06	\$43,792.01	\$101,221.05		
OVERTIME PAY	\$0.00		\$0.01	-\$0.01				
LOCAL FUND Total		\$766,965.96	\$220,123.70	\$546,842.26				
LONG TERM CARE OVERSIGHT DIVISION Total			\$2,270,279.80	\$598,962.02	\$1,671,317.78			
70272	LONG TERM CARE OPERATIONS DIVISION	FEDERAL GRANT FUND - FPR	CONTINUING FULL TIME	\$0.00	\$7,736.23	-\$7,736.23		
			CONTRACTUAL SERVICES - OTHER	\$1,846,534.00	\$0.00	\$1,754,825.69		
			FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$976.59	-\$976.59		
			GOVERNMENT SUBSIDIES & GRANTS	\$4,992,339.33	-\$14,732.17	\$4,151,540.23		
		FEDERAL GRANT FUND - FPR Total		\$6,838,873.33	-\$6,019.35	\$5,897,653.10		
		FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$754,574.42	\$173,333.91	\$581,240.51		
			CONTRACTUAL SERVICES - OTHER	\$4,661,598.52	\$506,419.81	\$1,347,566.30		
			FRINGE BENEFITS - CURR PERSONNEL	\$173,819.21	\$43,096.60	\$130,722.61		
			OVERTIME PAY	\$0.00	\$581.76	-\$581.76		
		FEDERAL MEDICAID PAYMENTS Total		\$5,589,992.15	\$723,432.08	\$2,058,947.66		
LOCAL FUND	CONTINUING FULL TIME	\$922,257.62	\$211,852.80	\$710,404.82				
	CONTRACTUAL SERVICES - OTHER	\$5,090,464.84	\$504,367.54	\$1,281,379.06				
	FRINGE BENEFITS - CURR PERSONNEL	\$212,445.71	\$52,674.12	\$159,771.59				
	OVERTIME PAY	\$0.00	\$711.04	-\$711.04				
LOCAL FUND Total		\$6,225,168.17	\$769,605.50	\$2,150,844.43				
LONG TERM CARE OPERATIONS DIVISION Total			\$18,654,033.65	\$1,487,018.23	\$10,107,445.19			
70273	INTAKE AND ASSESSMENT DIVISION	FEDERAL MEDICAID PAYMENTS	ADDITIONAL GROSS PAY	\$0.00	\$429.23	-\$429.23		
			CONTINUING FULL TIME	\$495,860.25	\$90,572.67	\$405,287.58		
			CONTRACTUAL SERVICES - OTHER	\$3,318,095.30	\$515,414.04	\$2,206,359.07		
			FRINGE BENEFITS - CURR PERSONNEL	\$115,039.59	\$29,009.95	\$86,029.64		
		FEDERAL MEDICAID PAYMENTS Total		\$3,928,995.14	\$635,425.89	\$2,697,247.06		
		LOCAL FUND	ADDITIONAL GROSS PAY	\$0.00	\$143.08	-\$143.08		
			CONTINUING FULL TIME	\$371,246.75	\$41,330.77	\$329,915.98		
			CONTRACTUAL SERVICES - OTHER	\$4,055,449.80	\$629,950.54	\$2,696,661.06		
			FRINGE BENEFITS - CURR PERSONNEL	\$86,129.24	\$14,091.77	\$72,037.47		
		LOCAL FUND Total		\$4,512,825.79	\$685,516.16	\$3,098,471.43		
INTAKE AND ASSESSMENT DIVISION Total			\$8,441,820.93	\$1,320,942.05	\$5,795,718.49			
70282	OFFICE OF THE GENERAL COUNSEL - HT0	LOCAL FUND	OTHER SERVICES & CHARGES	\$550.00	\$0.00	\$550.00		
		LOCAL FUND Total		\$550.00	\$0.00	\$550.00		
		OFFICE OF THE GENERAL COUNSEL - HT0 Total		\$550.00	\$0.00	\$550.00		
LONG TERM CARE PROGRAM Total			\$30,175,689.28	\$3,538,203.18	\$18,252,755.48			
MMIS SYSTEM AND INFRASTRUCTURE	70261	DIVISION OF CLAIMS MANAGEMENT	LOCAL FUND	CONTRACTUAL SERVICES - OTHER	\$0.00	-\$4,141,946.00	\$4,141,946.00	
			LOCAL FUND Total		\$0.00	-\$4,141,946.00	\$4,141,946.00	
		DIVISION OF CLAIMS MANAGEMENT Total		\$0.00	-\$4,141,946.00	\$4,141,946.00		
MMIS SYSTEM AND INFRASTRUCTURE Total			\$0.00	-\$4,141,946.00	\$4,141,946.00			
PROGRAM OVERSIGHT	70163	DIVISION OF CHILDREN'S HEALTH SERVICES	FEDERAL MEDICAID PAYMENTS	CONTINUING FULL TIME	\$0.00	\$0.00	\$0.00	
			CONTINUING FULL TIME - OTHERS	\$0.00	\$0.00	\$0.00		

				FRINGE BENEFITS - CURR PERSONNEL	\$0.00	\$0.00	\$0.00
				FEDERAL MEDICAID PAYMENTS Total	\$0.00	\$0.00	\$0.00
				DIVISION OF CHILDREN'S HEALTH SERVICES Total	\$0.00	\$0.00	\$0.00
PROGRAM OVERSIGHT Total					\$0.00	\$0.00	\$0.00
PROVIDER SERVICES	70164	INPATIENT IN STATE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$8,454,000.00	\$0.00	\$8,454,000.00
			DEDICATED TAXES Total		\$8,454,000.00	\$0.00	\$8,454,000.00
			FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$85,421,991.98	\$20,828,271.39	\$64,593,720.59
			FEDERAL MEDICAID PAYMENTS Total		\$85,421,991.98	\$20,828,271.39	\$64,593,720.59
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$49,237,609.15	\$8,926,402.03	\$40,311,207.12
			LOCAL FUND Total		\$49,237,609.15	\$8,926,402.03	\$40,311,207.12
		INPATIENT IN STATE Total			\$143,113,601.13	\$29,754,673.42	\$113,358,927.71
	70165	INPATIENT CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$167,106.05	\$87,141.48	\$79,964.57
			FEDERAL MEDICAID PAYMENTS Total		\$167,106.05	\$87,141.48	\$79,964.57
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$44,420.60	\$23,164.20	\$21,256.40
			LOCAL FUND Total		\$44,420.60	\$23,164.20	\$21,256.40
		INPATIENT CHIP Total			\$211,526.65	\$110,305.68	\$101,220.97
	70167	INPATIENT - GME PAYMENTS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$20,107,978.80	\$6,300,000.00	\$13,807,978.80
			FEDERAL MEDICAID PAYMENTS Total		\$20,107,978.80	\$6,300,000.00	\$13,807,978.80
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$6,853,069.61	\$2,700,000.00	\$4,153,069.61
			LOCAL FUND Total		\$6,853,069.61	\$2,700,000.00	\$4,153,069.61
		INPATIENT - GME PAYMENTS Total			\$26,961,048.41	\$9,000,000.00	\$17,961,048.41
	70168	MENTAL HEALTH FACILITY SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,156,961.21	\$129,289.22	\$1,027,671.99
			FEDERAL MEDICAID PAYMENTS Total		\$1,156,961.21	\$129,289.22	\$1,027,671.99
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$502,947.58	\$55,409.66	\$447,537.92
			LOCAL FUND Total		\$502,947.58	\$55,409.66	\$447,537.92
		MENTAL HEALTH FACILITY SERVICES Total			\$1,659,908.79	\$184,698.88	\$1,475,209.91
	70170	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,141,458.85	\$335,786.55	\$805,672.30
			FEDERAL MEDICAID PAYMENTS Total		\$1,141,458.85	\$335,786.55	\$805,672.30
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$491,274.70	\$143,908.52	\$347,366.18
			LOCAL FUND Total		\$491,274.70	\$143,908.52	\$347,366.18
		PSYCHIATRIC RESIDENTIAL TREATMENT FACIL. Total			\$1,632,733.55	\$479,695.07	\$1,153,038.48
	70171	NURSING FACILITY IN STATE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$21,354,413.29	\$0.00	\$21,354,413.29
			DEDICATED TAXES Total		\$21,354,413.29	\$0.00	\$21,354,413.29
			FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$229,053,724.10	\$61,294,954.96	\$167,758,769.14
			FEDERAL MEDICAID PAYMENTS Total		\$229,053,724.10	\$61,294,954.96	\$167,758,769.14
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$76,811,468.45	\$26,269,266.43	\$50,542,202.02
			LOCAL FUND Total		\$76,811,468.45	\$26,269,266.43	\$50,542,202.02
		NURSING FACILITY IN STATE Total			\$327,219,605.84	\$87,564,221.39	\$239,655,384.45
	70172	NURSING HOME QUALITY OF CARE SERVICES	DEDICATED TAXES	CONTRACTUAL SERVICES - OTHER	\$110,000.00	\$0.00	\$110,000.00
			DEDICATED TAXES Total		\$110,000.00	\$0.00	\$110,000.00
			FEDERAL MEDICAID PAYMENTS	CONTRACTUAL SERVICES - OTHER	\$90,000.00	-\$13,419.16	\$103,419.16
			FEDERAL MEDICAID PAYMENTS Total		\$90,000.00	-\$13,419.16	\$103,419.16
		NURSING HOME QUALITY OF CARE SERVICES Total			\$200,000.00	-\$13,419.16	\$213,419.16
	70173	ICF PRIVATE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$4,429,621.80	\$0.00	\$4,429,621.80
			DEDICATED TAXES Total		\$4,429,621.80	\$0.00	\$4,429,621.80
			FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$72,651,917.30	\$17,237,344.63	\$55,414,572.67
			FEDERAL MEDICAID PAYMENTS Total		\$72,651,917.30	\$17,237,344.63	\$55,414,572.67
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$26,706,914.18	\$7,387,433.41	\$19,319,480.77
			LOCAL FUND Total		\$26,706,914.18	\$7,387,433.41	\$19,319,480.77
		ICF PRIVATE Total			\$103,788,453.28	\$24,624,778.04	\$79,163,675.24
	70174	PHYSICIAN SERVICES-MEDICAID	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$10,469,386.77	\$2,730,880.82	\$7,738,505.95
			FEDERAL MEDICAID PAYMENTS Total		\$10,469,386.77	\$2,730,880.82	\$7,738,505.95
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$3,912,781.73	\$2,404,473.74	\$1,508,307.99
			LOCAL FUND Total		\$3,912,781.73	\$2,404,473.74	\$1,508,307.99
			SPECIAL PURPOSE REVENUE FUNDS	GOVERNMENT SUBSIDIES & GRANTS	\$189,021.12	\$0.00	\$189,021.12
			SPECIAL PURPOSE REVENUE FUNDS Total		\$189,021.12	\$0.00	\$189,021.12
		PHYSICIAN SERVICES-MEDICAID Total			\$14,571,189.62	\$5,135,354.56	\$9,435,835.06
	70175	PHYSICIAN SERVICES CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$28,908.35	\$10,593.77	\$18,314.58
			FEDERAL MEDICAID PAYMENTS Total		\$28,908.35	\$10,593.77	\$18,314.58
			LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$7,684.50	\$2,816.07	\$4,868.43
			LOCAL FUND Total		\$7,684.50	\$2,816.07	\$4,868.43
		PHYSICIAN SERVICES CHIP Total			\$36,592.85	\$13,409.84	\$23,183.01
	70176	OUTPATIENT HOSPITAL IN STATE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$4,960,666.96	\$1,383,782.67	\$3,576,884.29
			DEDICATED TAXES Total		\$4,960,666.96	\$1,383,782.67	\$3,576,884.29
			FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$11,577,786.10	\$3,235,178.80	\$8,342,607.30

		FEDERAL MEDICAID PAYMENTS Total		\$11,577,786.10	\$3,235,178.80	\$8,342,607.30
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$51,570,585.82	\$6,051,437.87	\$45,519,147.95
		LOCAL FUND Total		\$51,570,585.82	\$6,051,437.87	\$45,519,147.95
	OUTPATIENT HOSPITAL IN STATE Total			\$68,109,038.88	\$10,670,399.34	\$57,438,639.54
70177	OUTPATIENT HOSPITAL CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$52,401.30	\$15,500.67	\$36,900.63
		FEDERAL MEDICAID PAYMENTS Total		\$52,401.30	\$15,500.67	\$36,900.63
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$13,929.46	\$4,120.43	\$9,809.03
		LOCAL FUND Total		\$13,929.46	\$4,120.43	\$9,809.03
	OUTPATIENT HOSPITAL CHIP Total			\$66,330.76	\$19,621.10	\$46,709.66
70178	PRESCRIBED DRUGS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$43,154,840.46	-\$15,620,887.81	\$58,775,728.27
		FEDERAL MEDICAID PAYMENTS Total		\$43,154,840.46	-\$15,620,887.81	\$58,775,728.27
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$37,787,947.66	\$10,167,048.06	\$27,620,899.60
		LOCAL FUND Total		\$37,787,947.66	\$10,167,048.06	\$27,620,899.60
	PRESCRIBED DRUGS Total			\$80,942,788.12	-\$5,453,839.75	\$86,396,627.87
70179	PRESCRIBED DRUGS - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,042,866.93	\$15,691.38	\$2,027,175.55
		FEDERAL MEDICAID PAYMENTS Total		\$2,042,866.93	\$15,691.38	\$2,027,175.55
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$543,040.58	\$5,375.69	\$537,664.89
		LOCAL FUND Total		\$543,040.58	\$5,375.69	\$537,664.89
	PRESCRIBED DRUGS - CHIP Total			\$2,585,907.51	\$21,067.07	\$2,564,840.44
70180	DENTAL SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,630,711.77	\$793,593.52	\$1,837,118.25
		FEDERAL MEDICAID PAYMENTS Total		\$2,630,711.77	\$793,593.52	\$1,837,118.25
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,127,447.90	\$624,983.01	\$502,464.89
		LOCAL FUND Total		\$1,127,447.90	\$624,983.01	\$502,464.89
	DENTAL SERVICES Total			\$3,758,159.67	\$1,418,576.53	\$2,339,583.14
70181	DENTAL SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$35,344.52	\$13,219.36	\$22,125.16
		FEDERAL MEDICAID PAYMENTS Total		\$35,344.52	\$13,219.36	\$22,125.16
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$9,395.38	\$3,514.01	\$5,881.37
		LOCAL FUND Total		\$9,395.38	\$3,514.01	\$5,881.37
	DENTAL SERVICES - CHIP Total			\$44,739.90	\$16,733.37	\$28,006.53
70182	OTHER PRACTITIONERS' SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$6,576,974.00	\$106,997.71	\$6,469,976.29
		FEDERAL MEDICAID PAYMENTS Total		\$6,576,974.00	\$106,997.71	\$6,469,976.29
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$256,428.17	\$45,856.16	\$210,572.01
		LOCAL FUND Total		\$256,428.17	\$45,856.16	\$210,572.01
	OTHER PRACTITIONERS' SERVICES Total			\$6,833,402.17	\$152,853.87	\$6,680,548.30
70183	OTHER PRACTITIONERS' SERVICES CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,294.78	\$434.21	\$1,860.57
		FEDERAL MEDICAID PAYMENTS Total		\$2,294.78	\$434.21	\$1,860.57
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$610.00	\$115.42	\$494.58
		LOCAL FUND Total		\$610.00	\$115.42	\$494.58
	OTHER PRACTITIONERS' SERVICES CHIP Total			\$2,904.78	\$549.63	\$2,355.15
70184	CLINIC SERVICES - PRIVATE	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,702,085.43	\$999,435.34	\$1,702,650.09
		FEDERAL MEDICAID PAYMENTS Total		\$2,702,085.43	\$999,435.34	\$1,702,650.09
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,158,036.61	\$428,463.84	\$729,572.77
		LOCAL FUND Total		\$1,158,036.61	\$428,463.84	\$729,572.77
	CLINIC SERVICES - PRIVATE Total			\$3,860,122.04	\$1,427,899.18	\$2,432,222.86
70185	CLINIC SERVICES - PRIVATE CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$572.21	\$15.93	\$556.28
		FEDERAL MEDICAID PAYMENTS Total		\$572.21	\$15.93	\$556.28
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$152.11	\$4.23	\$147.88
		LOCAL FUND Total		\$152.11	\$4.23	\$147.88
	CLINIC SERVICES - PRIVATE CHIP Total			\$724.32	\$20.16	\$704.16
70186	CLINIC SERVICES - MENTAL HEALTH	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$5,544,649.19	\$49,960.45	\$5,494,688.74
		FEDERAL MEDICAID PAYMENTS Total		\$5,544,649.19	\$49,960.45	\$5,494,688.74
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,376,029.19	\$21,411.64	\$2,354,617.55
		LOCAL FUND Total		\$2,376,029.19	\$21,411.64	\$2,354,617.55
	CLINIC SERVICES - MENTAL HEALTH Total			\$7,920,678.38	\$71,372.09	\$7,849,306.29
70188	CLINIC SERVICES - MHRS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$183,105,002.20	\$36,982,232.63	\$146,122,769.57
		FEDERAL MEDICAID PAYMENTS Total		\$183,105,002.20	\$36,982,232.63	\$146,122,769.57
	CLINIC SERVICES - MHRS Total			\$183,105,002.20	\$36,982,232.63	\$146,122,769.57
70189	CLINIC SERVICES - MHRS CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,866,054.75	\$639,148.06	\$2,226,906.69
		FEDERAL MEDICAID PAYMENTS Total		\$2,866,054.75	\$639,148.06	\$2,226,906.69
	CLINIC SERVICES - MHRS CHIP Total			\$2,866,054.75	\$639,148.06	\$2,226,906.69
70190	LABORATORY & RADIOLOGICAL SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,661,416.97	\$962,090.10	\$2,699,326.87
		FEDERAL MEDICAID PAYMENTS Total		\$3,661,416.97	\$962,090.10	\$2,699,326.87
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,569,178.70	\$434,917.36	\$1,134,261.34
		LOCAL FUND Total		\$1,569,178.70	\$434,917.36	\$1,134,261.34
	LABORATORY & RADIOLOGICAL SERVICES Total			\$5,230,595.67	\$1,397,007.46	\$3,833,588.21

70191	LABORATORY & RADIOLOGICAL SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$14,263.45	\$3,962.53	\$10,300.92
		FEDERAL MEDICAID PAYMENTS Total		\$14,263.45	\$3,962.53	\$10,300.92
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$3,791.55	\$1,053.34	\$2,738.21
		LOCAL FUND Total		\$3,791.55	\$1,053.34	\$2,738.21
	LABORATORY & RADIOLOGICAL SERVICES -CHIP Total			\$18,055.00	\$5,015.87	\$13,039.13
70192	HOME HEALTH SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$6,090,633.61	\$938,534.30	\$5,152,099.31
		FEDERAL MEDICAID PAYMENTS Total		\$6,090,633.61	\$938,534.30	\$5,152,099.31
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,610,271.55	\$402,228.98	\$2,208,042.57
		LOCAL FUND Total		\$2,610,271.55	\$402,228.98	\$2,208,042.57
	HOME HEALTH SERVICES Total			\$8,700,905.16	\$1,340,763.28	\$7,360,141.88
70193	HOME HEALTH SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$26,636.26	\$0.00	\$26,636.26
		FEDERAL MEDICAID PAYMENTS Total		\$26,636.26	\$0.00	\$26,636.26
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$7,080.52	\$0.00	\$7,080.52
		LOCAL FUND Total		\$7,080.52	\$0.00	\$7,080.52
	HOME HEALTH SERVICES - CHIP Total			\$33,716.78	\$0.00	\$33,716.78
70194	STERILIZATIONS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$3,029.78	\$0.00	\$3,029.78
		FEDERAL MEDICAID PAYMENTS Total		\$3,029.78	\$0.00	\$3,029.78
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,298.48	\$0.00	\$1,298.48
		LOCAL FUND Total		\$1,298.48	\$0.00	\$1,298.48
	STERILIZATIONS Total			\$4,328.26	\$0.00	\$4,328.26
70195	EPSDT-MEDICAID	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$579,047.42	\$87,007.81	\$492,039.61
		FEDERAL MEDICAID PAYMENTS Total		\$579,047.42	\$87,007.81	\$492,039.61
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$248,163.18	\$37,289.06	\$210,874.12
		LOCAL FUND Total		\$248,163.18	\$37,289.06	\$210,874.12
	EPSDT-MEDICAID Total			\$827,210.60	\$124,296.87	\$702,913.73
70196	EPSDT SCREENING SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$26,230.30	\$1,797.58	\$24,432.72
		FEDERAL MEDICAID PAYMENTS Total		\$26,230.30	\$1,797.58	\$24,432.72
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$6,972.61	\$477.81	\$6,494.80
		LOCAL FUND Total		\$6,972.61	\$477.81	\$6,494.80
	EPSDT SCREENING SERVICES - CHIP Total			\$33,202.91	\$2,275.39	\$30,927.52
70197	MEDICAID PART A	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$16,022,070.29	\$2,843,137.50	\$13,178,932.79
		FEDERAL MEDICAID PAYMENTS Total		\$16,022,070.29	\$2,843,137.50	\$13,178,932.79
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$6,866,601.55	\$1,218,487.50	\$5,648,114.05
		LOCAL FUND Total		\$6,866,601.55	\$1,218,487.50	\$5,648,114.05
	MEDICAID PART A Total			\$22,888,671.84	\$4,061,625.00	\$18,827,046.84
70198	MEDICAID PART B	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$64,329,683.65	\$14,463,229.13	\$49,866,454.52
		FEDERAL MEDICAID PAYMENTS Total		\$64,329,683.65	\$14,463,229.13	\$49,866,454.52
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$27,569,864.42	\$6,198,526.77	\$21,371,337.65
		LOCAL FUND Total		\$27,569,864.42	\$6,198,526.77	\$21,371,337.65
	MEDICAID PART B Total			\$91,899,548.07	\$20,661,755.90	\$71,237,792.17
70199	MEDICAID PART B - NON FFP	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$7,209,878.92	\$1,127,062.30	\$6,082,816.62
		LOCAL FUND Total		\$7,209,878.92	\$1,127,062.30	\$6,082,816.62
		MEDICAID PART B - NON FFP Total		\$7,209,878.92	\$1,127,062.30	\$6,082,816.62
70200	MANAGED CARE ORGANIZATIONS (MCO)	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$170,409,569.07	\$0.00	\$170,409,569.07
		DEDICATED TAXES Total		\$170,409,569.07	\$0.00	\$170,409,569.07
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$624,223,773.60	\$57,298,537.88	\$566,925,235.72
		FEDERAL MEDICAID PAYMENTS Total		\$624,223,773.60	\$57,298,537.88	\$566,925,235.72
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$82,073,120.48	\$51,896,823.34	\$30,176,297.14
		LOCAL FUND Total		\$82,073,120.48	\$51,896,823.34	\$30,176,297.14
	MANAGED CARE ORGANIZATIONS (MCO) Total			\$876,706,463.15	\$109,195,361.22	\$767,511,101.93
70201	MANAGED CARE ORGANIZATIONS (MCO) - C	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$5,967,527.55	\$2,481,331.96	\$3,486,195.59
		DEDICATED TAXES Total		\$5,967,527.55	\$2,481,331.96	\$3,486,195.59
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$71,792,550.30	\$6,331,073.87	\$65,461,476.43
		FEDERAL MEDICAID PAYMENTS Total		\$71,792,550.30	\$6,331,073.87	\$65,461,476.43
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$14,705,827.04	\$1,989,422.03	\$12,716,405.01
		LOCAL FUND Total		\$14,705,827.04	\$1,989,422.03	\$12,716,405.01
	MANAGED CARE ORGANIZATIONS (MCO) - CHIP Total			\$92,465,904.89	\$10,801,827.86	\$81,664,077.03
70202	CASSIP	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$4,673,296.94	\$590,219.04	\$4,083,077.90
		DEDICATED TAXES Total		\$4,673,296.94	\$590,219.04	\$4,083,077.90
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$146,202,050.20	\$31,019,400.07	\$115,182,650.13
		FEDERAL MEDICAID PAYMENTS Total		\$146,202,050.20	\$31,019,400.07	\$115,182,650.13
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$57,861,677.35	\$13,525,805.01	\$44,335,872.34
		LOCAL FUND Total		\$57,861,677.35	\$13,525,805.01	\$44,335,872.34
	CASSIP Total			\$208,737,024.49	\$45,135,424.12	\$163,601,600.37
70203	PERSONAL CARE SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$70,500,107.95	\$20,108,419.88	\$50,391,688.07

		FEDERAL MEDICAID PAYMENTS Total		\$70,500,107.95	\$20,108,419.88	\$50,391,688.07
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$30,214,331.98	\$8,617,894.28	\$21,596,437.70
		LOCAL FUND Total		\$30,214,331.98	\$8,617,894.28	\$21,596,437.70
	PERSONAL CARE SERVICES Total			\$100,714,439.93	\$28,726,314.16	\$71,988,125.77
70205	HOSPICE BENEFITS	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,222,111.19	\$401,823.29	\$3,820,287.90
		FEDERAL MEDICAID PAYMENTS Total		\$4,222,111.19	\$401,823.29	\$3,820,287.90
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,809,476.22	\$172,209.98	\$1,637,266.24
		LOCAL FUND Total		\$1,809,476.22	\$172,209.98	\$1,637,266.24
	HOSPICE BENEFITS Total			\$6,031,587.41	\$574,033.27	\$5,457,554.14
70206	FEDERALLY-QUALIFIED HEALTH CENTER	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$14,679,377.99	\$1,181,154.07	\$13,498,223.92
		FEDERAL MEDICAID PAYMENTS Total		\$14,679,377.99	\$1,181,154.07	\$13,498,223.92
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$32,095,836.40	\$2,865,092.88	\$29,230,743.52
		LOCAL FUND Total		\$32,095,836.40	\$2,865,092.88	\$29,230,743.52
	FEDERALLY-QUALIFIED HEALTH CENTER Total			\$46,775,214.39	\$4,046,246.95	\$42,728,967.44
70207	FEDERALLY-QUALIFIED HEALTH CENTER -	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,725,419.95	\$10,467.14	\$1,714,952.81
		FEDERAL MEDICAID PAYMENTS Total		\$1,725,419.95	\$10,467.14	\$1,714,952.81
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$458,655.94	\$2,782.42	\$455,873.52
		LOCAL FUND Total		\$458,655.94	\$2,782.42	\$455,873.52
	FEDERALLY-QUALIFIED HEALTH CENTER - CHIP Total			\$2,184,075.89	\$13,249.56	\$2,170,826.33
70208	NON-EMERGENCY MEDICAL TRANSPORTATION	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$17,026,288.80	\$2,712,684.08	\$14,313,604.72
		FEDERAL MEDICAID PAYMENTS Total		\$17,026,288.80	\$2,712,684.08	\$14,313,604.72
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$7,788,912.24	\$1,285,593.30	\$6,503,318.94
		LOCAL FUND Total		\$7,788,912.24	\$1,285,593.30	\$6,503,318.94
	NON-EMERGENCY MEDICAL TRANSPORTATION Total			\$24,815,201.04	\$3,998,277.38	\$20,816,923.66
70209	NON-EMERGENCY MEDICAL TRANSPORT. -	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$101,945.16	\$18,177.53	\$83,767.63
		FEDERAL MEDICAID PAYMENTS Total		\$101,945.16	\$18,177.53	\$83,767.63
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$27,099.35	\$4,831.99	\$22,267.36
		LOCAL FUND Total		\$27,099.35	\$4,831.99	\$22,267.36
	NON-EMERGENCY MEDICAL TRANSPORT. - CHIP Total			\$129,044.51	\$23,009.52	\$106,034.99
70210	PHYSICAL THERAPY	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$53,017.40	\$9,079.02	\$43,938.38
		FEDERAL MEDICAID PAYMENTS Total		\$53,017.40	\$9,079.02	\$43,938.38
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$22,721.74	\$3,891.03	\$18,830.71
		LOCAL FUND Total		\$22,721.74	\$3,891.03	\$18,830.71
	PHYSICAL THERAPY Total			\$75,739.14	\$12,970.05	\$62,769.09
70211	PHYSICAL THERAPY - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,005.42	\$0.00	\$1,005.42
		FEDERAL MEDICAID PAYMENTS Total		\$1,005.42	\$0.00	\$1,005.42
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$267.26	\$0.00	\$267.26
		LOCAL FUND Total		\$267.26	\$0.00	\$267.26
	PHYSICAL THERAPY - CHIP Total			\$1,272.68	\$0.00	\$1,272.68
70212	PROSTHETIC DEVICES, DENTURES, EYEGLASSES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,227,618.48	\$221,778.75	\$1,005,839.73
		FEDERAL MEDICAID PAYMENTS Total		\$1,227,618.48	\$221,778.75	\$1,005,839.73
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$526,122.21	\$95,048.03	\$431,074.18
		LOCAL FUND Total		\$526,122.21	\$95,048.03	\$431,074.18
	PROSTHETIC DEVICES, DENTURES, EYEGLASSES Total			\$1,753,740.69	\$316,826.78	\$1,436,913.91
70213	PROSTHETIC DVCS,DENTURES,EYEGLASSES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,404.82	-\$47.57	\$1,452.39
		FEDERAL MEDICAID PAYMENTS Total		\$1,404.82	-\$47.57	\$1,452.39
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$373.43	-\$12.64	\$386.07
		LOCAL FUND Total		\$373.43	-\$12.64	\$386.07
	PROSTHETIC DVCS,DENTURES,EYEGLASSES-CHIP Total			\$1,778.25	-\$60.21	\$1,838.46
70214	NURSE MID-WIFE	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$57,257.00	\$8,038.78	\$49,218.22
		FEDERAL MEDICAID PAYMENTS Total		\$57,257.00	\$8,038.78	\$49,218.22
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$24,538.72	\$3,139.44	\$21,399.28
		LOCAL FUND Total		\$24,538.72	\$3,139.44	\$21,399.28
	NURSE MID-WIFE Total			\$81,795.72	\$11,178.22	\$70,617.50
70215	EMERGENCY HOSPITAL SERVICES	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$1,642,333.04	\$0.00	\$1,642,333.04
		DEDICATED TAXES Total		\$1,642,333.04	\$0.00	\$1,642,333.04
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,973,445.47	\$1,154,058.68	\$3,819,386.79
		FEDERAL MEDICAID PAYMENTS Total		\$4,973,445.47	\$1,154,058.68	\$3,819,386.79
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$497,856.06	\$496,264.80	\$1,591.26
		LOCAL FUND Total		\$497,856.06	\$496,264.80	\$1,591.26
	EMERGENCY HOSPITAL SERVICES Total			\$7,113,634.57	\$1,650,323.48	\$5,463,311.09
70216	EMERGENCY HOSPITAL SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$53,533.28	\$13,852.83	\$39,680.45
		FEDERAL MEDICAID PAYMENTS Total		\$53,533.28	\$13,852.83	\$39,680.45
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$14,230.37	\$3,682.41	\$10,547.96
		LOCAL FUND Total		\$14,230.37	\$3,682.41	\$10,547.96

	EMERGENCY HOSPITAL SERVICES - CHIP Total			\$67,763.65	\$17,535.24	\$50,228.41
70217	NURSE PRACTITIONER SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,702,875.63	\$1,092,886.41	\$1,609,989.22
		FEDERAL MEDICAID PAYMENTS Total		\$2,702,875.63	\$1,092,886.41	\$1,609,989.22
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,158,375.27	\$477,978.11	\$680,397.16
		LOCAL FUND Total		\$1,158,375.27	\$477,978.11	\$680,397.16
	NURSE PRACTITIONER SERVICES Total			\$3,861,250.90	\$1,570,864.52	\$2,290,386.38
70218	NURSE PRACTITIONER SERVICES - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$7,263.12	\$906.23	\$6,356.89
		FEDERAL MEDICAID PAYMENTS Total		\$7,263.12	\$906.23	\$6,356.89
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,930.70	\$240.90	\$1,689.80
		LOCAL FUND Total		\$1,930.70	\$240.90	\$1,689.80
	NURSE PRACTITIONER SERVICES - CHIP Total			\$9,193.82	\$1,147.13	\$8,046.69
70219	PRIVATE DUTY NURSING	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$16,555,028.94	\$3,187,353.14	\$13,367,675.80
		FEDERAL MEDICAID PAYMENTS Total		\$16,555,028.94	\$3,187,353.14	\$13,367,675.80
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$7,095,012.40	\$1,366,008.49	\$5,729,003.91
		LOCAL FUND Total		\$7,095,012.40	\$1,366,008.49	\$5,729,003.91
	PRIVATE DUTY NURSING Total			\$23,650,041.34	\$4,553,361.63	\$19,096,679.71
70221	DURABLE MED EQUIP (DME)-MEDICAID	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$6,640,999.02	\$3,470,594.33	\$3,170,404.69
		FEDERAL MEDICAID PAYMENTS Total		\$6,640,999.02	\$3,470,594.33	\$3,170,404.69
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$2,846,142.44	\$1,751,332.88	\$1,094,809.56
		LOCAL FUND Total		\$2,846,142.44	\$1,751,332.88	\$1,094,809.56
	DURABLE MED EQUIP (DME)-MEDICAID Total			\$9,487,141.46	\$5,221,927.21	\$4,265,214.25
70222	DURABLE MED EQUIP (DME)-MEDICAID - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,130.86	\$263.67	\$1,867.19
		FEDERAL MEDICAID PAYMENTS Total		\$2,130.86	\$263.67	\$1,867.19
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$566.43	\$70.09	\$496.34
		LOCAL FUND Total		\$566.43	\$70.09	\$496.34
	DURABLE MED EQUIP (DME)-MEDICAID - CHIP Total			\$2,697.29	\$333.76	\$2,363.53
70223	COBRA/RECIPIENT OOP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$69,892.36	\$37,026.86	\$32,865.50
		FEDERAL MEDICAID PAYMENTS Total		\$69,892.36	\$37,026.86	\$32,865.50
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$29,953.87	\$15,868.65	\$14,085.22
		LOCAL FUND Total		\$29,953.87	\$15,868.65	\$14,085.22
	COBRA/RECIPIENT OOP Total			\$99,846.23	\$52,895.51	\$46,950.72
70225	OPTIONAL STATE SUPPLEMENT PAYMENTS	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$5,403,324.22	\$1,253,008.45	\$4,150,315.77
		LOCAL FUND Total		\$5,403,324.22	\$1,253,008.45	\$4,150,315.77
	OPTIONAL STATE SUPPLEMENT PAYMENTS Total			\$5,403,324.22	\$1,253,008.45	\$4,150,315.77
70226	PART-D CLAWBACK	LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$36,413,380.35	\$4,928,890.41	\$31,484,489.94
		LOCAL FUND Total		\$36,413,380.35	\$4,928,890.41	\$31,484,489.94
	PART-D CLAWBACK Total			\$36,413,380.35	\$4,928,890.41	\$31,484,489.94
70228	IDD WAIVER	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$283,291,008.30	\$61,562,841.46	\$221,728,166.84
		FEDERAL MEDICAID PAYMENTS Total		\$283,291,008.30	\$61,562,841.46	\$221,728,166.84
	IDD WAIVER Total			\$283,291,008.30	\$61,562,841.46	\$221,728,166.84
70229	EPD WAIVER	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$142,500,241.20	\$37,661,734.09	\$104,838,507.11
		FEDERAL MEDICAID PAYMENTS Total		\$142,500,241.20	\$37,661,734.09	\$104,838,507.11
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$61,071,531.93	\$16,140,743.18	\$44,930,788.75
		LOCAL FUND Total		\$61,071,531.93	\$16,140,743.18	\$44,930,788.75
	EPD WAIVER Total			\$203,571,773.13	\$53,802,477.27	\$149,769,295.86
70230	ADULT DAY HEALTH	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,435,394.10	\$476,273.78	\$1,959,120.32
		FEDERAL MEDICAID PAYMENTS Total		\$2,435,394.10	\$476,273.78	\$1,959,120.32
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,043,740.33	\$204,117.33	\$839,623.00
		LOCAL FUND Total		\$1,043,740.33	\$204,117.33	\$839,623.00
	ADULT DAY HEALTH Total			\$3,479,134.43	\$680,391.11	\$2,798,743.32
70231	MCO-NEWLY ELIGIBLE	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$24,918,217.34	\$14,124,372.85	\$10,793,844.49
		DEDICATED TAXES Total		\$24,918,217.34	\$14,124,372.85	\$10,793,844.49
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$987,233,417.50	\$178,077,150.58	\$809,156,266.92
		FEDERAL MEDICAID PAYMENTS Total		\$987,233,417.50	\$178,077,150.58	\$809,156,266.92
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$84,774,384.84	\$23,446,087.86	\$61,328,296.98
		LOCAL FUND Total		\$84,774,384.84	\$23,446,087.86	\$61,328,296.98
	MCO-NEWLY ELIGIBLE Total			\$1,096,926,019.68	\$215,647,611.29	\$881,278,408.39
70232	EMERGENCY MEDICAID (NON MEDICAID POP.)	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,641,912.17	\$6,548,399.97	-\$1,906,487.80
		FEDERAL MEDICAID PAYMENTS Total		\$4,641,912.17	\$6,548,399.97	-\$1,906,487.80
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$1,989,390.93	\$2,806,457.14	-\$817,066.21
		LOCAL FUND Total		\$1,989,390.93	\$2,806,457.14	-\$817,066.21
	EMERGENCY MEDICAID (NON MEDICAID POP.) Total			\$6,631,303.10	\$9,354,857.11	-\$2,723,554.01
70233	ICF SUPPLEMENTAL PAYMENTS	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$780,000.00	\$0.00	\$780,000.00
		DEDICATED TAXES Total		\$780,000.00	\$0.00	\$780,000.00
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,820,000.00	\$0.00	\$1,820,000.00

		FEDERAL MEDICAID PAYMENTS Total	\$1,820,000.00	\$0.00	\$1,820,000.00
	ICF SUPPLEMENTAL PAYMENTS Total		\$2,600,000.00	\$0.00	\$2,600,000.00
70234	APRA ASARS: ADULT SUBSTANCE ABUSE	FEDERAL MEDICAID PAYMENTS	\$295,328.54	\$832,700.66	-\$537,372.12
		FEDERAL MEDICAID PAYMENTS Total	\$295,328.54	\$832,700.66	-\$537,372.12
	APRA ASARS: ADULT SUBSTANCE ABUSE Total		\$295,328.54	\$832,700.66	-\$537,372.12
70235	APRA ASTEP: CHILD SUBSTANCE ABUSE	FEDERAL MEDICAID PAYMENTS	\$11,392.62	\$51,958.34	-\$40,565.72
		FEDERAL MEDICAID PAYMENTS Total	\$11,392.62	\$51,958.34	-\$40,565.72
	APRA ASTEP: CHILD SUBSTANCE ABUSE Total		\$11,392.62	\$51,958.34	-\$40,565.72
70236	MCO- EXPANSION POPLULATION	DEDICATED TAXES	\$0.00	\$432,484.23	-\$432,484.23
		DEDICATED TAXES Total	\$0.00	\$432,484.23	-\$432,484.23
		FEDERAL MEDICAID PAYMENTS	\$29,221,786.33	\$5,639,412.62	\$23,582,373.71
		FEDERAL MEDICAID PAYMENTS Total	\$29,221,786.33	\$5,639,412.62	\$23,582,373.71
		LOCAL FUND	\$3,246,865.15	\$717,912.45	\$2,528,952.70
		LOCAL FUND Total	\$3,246,865.15	\$717,912.45	\$2,528,952.70
	MCO- EXPANSION POPLULATION Total		\$32,468,651.48	\$6,789,809.30	\$25,678,842.18
70237	DHCF - HEALTH HOMES I	FEDERAL MEDICAID PAYMENTS	\$271,570.29	\$0.00	\$271,570.29
		FEDERAL MEDICAID PAYMENTS Total	\$271,570.29	\$0.00	\$271,570.29
	DHCF - HEALTH HOMES I Total		\$271,570.29	\$0.00	\$271,570.29
70238	HEALTH HOMES II	FEDERAL MEDICAID PAYMENTS	\$1,756,007.24	\$317,112.54	\$1,438,894.70
		FEDERAL MEDICAID PAYMENTS Total	\$1,756,007.24	\$317,112.54	\$1,438,894.70
		LOCAL FUND	\$752,574.53	\$135,905.39	\$616,669.14
		LOCAL FUND Total	\$752,574.53	\$135,905.39	\$616,669.14
	HEALTH HOMES II Total		\$2,508,581.77	\$453,017.93	\$2,055,563.84
70239	PROGRAM OF ALL-INCLUSIVE CARE (PACE)	FEDERAL MEDICAID PAYMENTS	\$5,236,814.04	\$699,495.14	\$4,537,318.90
		FEDERAL MEDICAID PAYMENTS Total	\$5,236,814.04	\$699,495.14	\$4,537,318.90
		LOCAL FUND	\$2,244,348.87	\$299,783.64	\$1,944,565.23
		LOCAL FUND Total	\$2,244,348.87	\$299,783.64	\$1,944,565.23
	PROGRAM OF ALL-INCLUSIVE CARE (PACE) Total		\$7,481,162.91	\$999,278.78	\$6,481,884.13
70241	MENTAL HEALTH FACILITY - CHIP	FEDERAL MEDICAID PAYMENTS	\$43,668.92	\$0.00	\$43,668.92
		FEDERAL MEDICAID PAYMENTS Total	\$43,668.92	\$0.00	\$43,668.92
		LOCAL FUND	\$11,608.19	\$0.00	\$11,608.19
		LOCAL FUND Total	\$11,608.19	\$0.00	\$11,608.19
	MENTAL HEALTH FACILITY - CHIP Total		\$55,277.11	\$0.00	\$55,277.11
70242	CASSIP - CHIP	DEDICATED TAXES	\$0.00	\$30,659.14	-\$30,659.14
		DEDICATED TAXES Total	\$0.00	\$30,659.14	-\$30,659.14
		FEDERAL MEDICAID PAYMENTS	\$4,197,694.89	\$1,394,719.62	\$2,802,975.27
		FEDERAL MEDICAID PAYMENTS Total	\$4,197,694.89	\$1,394,719.62	\$2,802,975.27
		LOCAL FUND	\$1,115,842.94	\$370,748.26	\$745,094.68
		LOCAL FUND Total	\$1,115,842.94	\$370,748.26	\$745,094.68
	CASSIP - CHIP Total		\$5,313,537.83	\$1,796,127.02	\$3,517,410.81
70243	IFS WAIVER	FEDERAL MEDICAID PAYMENTS	\$2,035,686.43	\$351,332.13	\$1,684,354.30
		FEDERAL MEDICAID PAYMENTS Total	\$2,035,686.43	\$351,332.13	\$1,684,354.30
	IFS WAIVER Total		\$2,035,686.43	\$351,332.13	\$1,684,354.30
70244	DC PUBLIC SCHOOLS	FEDERAL MEDICAID PAYMENTS	\$1,000,000.00	\$744,245.55	\$255,754.45
		FEDERAL MEDICAID PAYMENTS Total	\$1,000,000.00	\$744,245.55	\$255,754.45
	DC PUBLIC SCHOOLS Total		\$1,000,000.00	\$744,245.55	\$255,754.45
70245	DC PUBLIC SCHOOLS - CHIP	FEDERAL MEDICAID PAYMENTS	\$1,000,000.00	\$0.00	\$1,000,000.00
		FEDERAL MEDICAID PAYMENTS Total	\$1,000,000.00	\$0.00	\$1,000,000.00
	DC PUBLIC SCHOOLS - CHIP Total		\$1,000,000.00	\$0.00	\$1,000,000.00
70246	DC CHARTER SCHOOLS	FEDERAL MEDICAID PAYMENTS	\$7,000,000.00	\$1,528,207.47	\$5,471,792.53
		FEDERAL MEDICAID PAYMENTS Total	\$7,000,000.00	\$1,528,207.47	\$5,471,792.53
	DC CHARTER SCHOOLS Total		\$7,000,000.00	\$1,528,207.47	\$5,471,792.53
70247	DC CHARTER SCHOOLS - CHIP	FEDERAL MEDICAID PAYMENTS	\$1,000,000.00	\$36,415.44	\$963,584.56
		FEDERAL MEDICAID PAYMENTS Total	\$1,000,000.00	\$36,415.44	\$963,584.56
	DC CHARTER SCHOOLS - CHIP Total		\$1,000,000.00	\$36,415.44	\$963,584.56
70248	OSSE-CHILDREN W/SPCL NEEDS TRNSPT	FEDERAL MEDICAID PAYMENTS	\$26,000,000.00	\$1,450,384.70	\$24,549,615.30
		FEDERAL MEDICAID PAYMENTS Total	\$26,000,000.00	\$1,450,384.70	\$24,549,615.30
	OSSE-CHILDREN W/SPCL NEEDS TRNSPT Total		\$26,000,000.00	\$1,450,384.70	\$24,549,615.30
70249	OSSE-CHILDREN W/SPCL NEEDS TRNSPT - C	FEDERAL MEDICAID PAYMENTS	\$2,000,000.00	\$311,475.78	\$1,688,524.22
		FEDERAL MEDICAID PAYMENTS Total	\$2,000,000.00	\$311,475.78	\$1,688,524.22
	OSSE-CHILDREN W/SPCL NEEDS TRNSPT - CHIP Total		\$2,000,000.00	\$311,475.78	\$1,688,524.22
70250	DBH - REHAB OPTION	FEDERAL MEDICAID PAYMENTS	\$2,000,000.00	\$427,893.65	\$1,572,106.35
		FEDERAL MEDICAID PAYMENTS Total	\$2,000,000.00	\$427,893.65	\$1,572,106.35
	DBH - REHAB OPTION Total		\$2,000,000.00	\$427,893.65	\$1,572,106.35
70251	DBH - REHAB OPTION - CHIP	FEDERAL MEDICAID PAYMENTS	\$8,052.00	\$0.00	\$8,052.00

		FEDERAL MEDICAID PAYMENTS Total		\$8,052.00	\$0.00	\$8,052.00
	DBH - REHAB OPTION - CHIP Total			\$8,052.00	\$0.00	\$8,052.00
70252	SAINT ELIZABETHS HOSPITAL	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$2,000,000.00	\$0.00	\$2,000,000.00
		FEDERAL MEDICAID PAYMENTS Total		\$2,000,000.00	\$0.00	\$2,000,000.00
	SAINT ELIZABETHS HOSPITAL Total			\$2,000,000.00	\$0.00	\$2,000,000.00
70253	ST ELIZBETHS HSPTL DSH (M.H. FCLTY DSH)	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$4,581,595.00	\$0.00	\$4,581,595.00
		FEDERAL MEDICAID PAYMENTS Total		\$4,581,595.00	\$0.00	\$4,581,595.00
	ST ELIZBETHS HSPTL DSH (M.H. FCLTY DSH) Total			\$4,581,595.00	\$0.00	\$4,581,595.00
70254	CHILD & FAMILY SERVICES (CFSA)	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,000,000.00	\$19,271.26	\$980,728.74
		FEDERAL MEDICAID PAYMENTS Total		\$1,000,000.00	\$19,271.26	\$980,728.74
	CHILD & FAMILY SERVICES (CFSA) Total			\$1,000,000.00	\$19,271.26	\$980,728.74
70255	FIRE & EMS SVS. (AMBULANCE)	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$87,291,465.80	\$8,759,850.58	\$78,531,615.22
		FEDERAL MEDICAID PAYMENTS Total		\$87,291,465.80	\$8,759,850.58	\$78,531,615.22
	FIRE & EMS SVS. (AMBULANCE) Total			\$87,291,465.80	\$8,759,850.58	\$78,531,615.22
70256	FIRE & EMS SVS. (AMBULANCE) - CHIP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$1,000,000.00	\$141,097.43	\$858,902.57
		FEDERAL MEDICAID PAYMENTS Total		\$1,000,000.00	\$141,097.43	\$858,902.57
	FIRE & EMS SVS. (AMBULANCE) - CHIP Total			\$1,000,000.00	\$141,097.43	\$858,902.57
70451	BEHAVIORAL HEALTH TRANSFORMATION V	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$10,099,404.88	\$407,927.88	\$9,691,477.00
		FEDERAL MEDICAID PAYMENTS Total		\$10,099,404.88	\$407,927.88	\$9,691,477.00
	BEHAVIORAL HEALTH TRANSFORMATION WAIVER - MEDICAID Total			\$10,099,404.88	\$407,927.88	\$9,691,477.00
70456	PSYCHIATRIC RESIDENTIAL TREATMENT F	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$12,768.49	\$0.00	\$12,768.49
		FEDERAL MEDICAID PAYMENTS Total		\$12,768.49	\$0.00	\$12,768.49
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$3,394.16	\$0.00	\$3,394.16
		LOCAL FUND Total		\$3,394.16	\$0.00	\$3,394.16
	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY - CHIP Total			\$16,162.65	\$0.00	\$16,162.65
70481	PERMANENT SUPPORTIVE HOUSING	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$30,107,996.59	\$6,050,693.28	\$24,057,303.31
		FEDERAL MEDICAID PAYMENTS Total		\$30,107,996.59	\$6,050,693.28	\$24,057,303.31
	PERMANENT SUPPORTIVE HOUSING Total			\$30,107,996.59	\$6,050,693.28	\$24,057,303.31
70482	PERMANENT SUPPORTIVE HOUSING-GROUP	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$16,962,824.15	\$2,717,072.48	\$14,245,751.67
		FEDERAL MEDICAID PAYMENTS Total		\$16,962,824.15	\$2,717,072.48	\$14,245,751.67
	PERMANENT SUPPORTIVE HOUSING-GROUP V111 Total			\$16,962,824.15	\$2,717,072.48	\$14,245,751.67
70487	DUAL CHOICE	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$218,458,515.07	\$53,617,981.23	\$164,840,533.84
		FEDERAL MEDICAID PAYMENTS Total		\$218,458,515.07	\$53,617,981.23	\$164,840,533.84
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$93,625,077.89	\$22,979,134.81	\$70,645,943.08
		LOCAL FUND Total		\$93,625,077.89	\$22,979,134.81	\$70,645,943.08
	DUAL CHOICE Total			\$312,083,592.96	\$76,597,116.04	\$235,486,476.92
70499	EMERGENCY MEDICAID GROUP VIII	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$41,980,920.20	\$0.00	\$41,980,920.20
		FEDERAL MEDICAID PAYMENTS Total		\$41,980,920.20	\$0.00	\$41,980,920.20
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$4,664,546.69	\$0.00	\$4,664,546.69
		LOCAL FUND Total		\$4,664,546.69	\$0.00	\$4,664,546.69
	EMERGENCY MEDICAID GROUP VIII Total			\$46,645,466.89	\$0.00	\$46,645,466.89
70500	MCO-ABD	DEDICATED TAXES	GOVERNMENT SUBSIDIES & GRANTS	\$37,166,895.92	\$68,846,279.48	-\$31,679,383.56
		DEDICATED TAXES Total		\$37,166,895.92	\$68,846,279.48	-\$31,679,383.56
		FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$320,526,715.50	\$34,495,475.00	\$286,031,240.50
		FEDERAL MEDICAID PAYMENTS Total		\$320,526,715.50	\$34,495,475.00	\$286,031,240.50
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$100,201,697.70	\$14,783,774.99	\$85,417,922.71
		LOCAL FUND Total		\$100,201,697.70	\$14,783,774.99	\$85,417,922.71
	MCO-ABD Total			\$457,895,309.12	\$118,125,529.47	\$339,769,779.65
70501	DOULA SERVICES	FEDERAL MEDICAID PAYMENTS	GOVERNMENT SUBSIDIES & GRANTS	\$483,458.75	\$0.00	\$483,458.75
		FEDERAL MEDICAID PAYMENTS Total		\$483,458.75	\$0.00	\$483,458.75
		LOCAL FUND	GOVERNMENT SUBSIDIES & GRANTS	\$207,196.61	\$0.00	\$207,196.61
		LOCAL FUND Total		\$207,196.61	\$0.00	\$207,196.61
	DOULA SERVICES Total			\$690,655.36	\$0.00	\$690,655.36
PROVIDER SERVICES Total				\$5,220,241,135.84	\$1,023,284,682.70	\$4,196,956,453.14
Grand Total				\$5,504,769,104.48	\$1,053,759,067.27	\$4,382,640,046.11

- 9. Please provide the following budget information, in Microsoft Excel, for the agency, including the amount budgeted and actually spent for FY 2025 and FY 2026, 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 Account Group and Account;**
 - b. At the program level, please provide the information broken out by source of funds and by Account Group and Account; and,**
 - c. At the Cost Center level, please provide the information broken out by source of funds and by Account Group.**

Response:

Please see Attachment 1 to Q9.

Question

11. Please provide a complete accounting of all reprogramming received by or transferred from 1

the agency in FY 2025 and FY 2026, to date.

Department of Health Care Finance (DHCF) Performance Oversight Hearing Question 11 DHCF Reprogrammings FY2025 & FY2026 Fiscal Year 2025 and 2026 Fiscal Year 2025																
Request	Request Amount	Description/Justification	Fund	Project	Award	Program	Cost Center	Account	Amount	Fund	Project	Award	Program	Cost Center	Account	Amount
Reprogramming Adjustment 1	\$1,434,396.80	The reprogramming was necessary necessary to align the Health Care Reform and Innovation Administration (HCRIA) and Request for Telecom Services (RTS) budgets authority with the anticipated expenditures .	1010001-LOCAL FUNDS	No Project	No Award	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV1 (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,375,000	1010001-LOCAL FUNDS	No Project	No Award	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV1 (HT0)	713200C- CONTRACTUAL SERVICES - OTHER	\$220,000
			1010001-LOCAL FUNDS	No Project	No Award	100071-TECHNOLOGY SERVICES - GENERAL	70268-INFORMATION TECHNOLOGY DIVISION - HT0 (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$115,000	1010001-LOCAL FUNDS	402062 - 10.02 - T001DC Net	1000103 - HT0.0100 LOCAL FUNDS	1001032-CHIEF OPERATING OFFICE	70489-CHIEF OPERATING OFFICER, ADMINISTRATIVE FUNCTIONS (HT0)	711100C-OTHER SERVICES & CHARGES	\$55,000
			1010001-LOCAL FUNDS	No Project	No Award	100102-CHIEF OPERATING OFFICE	70489-CHIEF OPERATING OFFICER, ADMINISTRATIVE FUNCTIONS (HT0)	71700C-PURCHASES EQUIPMENT & MACHINERY	\$14,397	1010001-LOCAL FUNDS	200084 - 25.33 - CHIEF OPERATING OFFICER- ADMINISTRATIVE FUNCTIONS / CHIEF OPERA	1000103 - HT0.0100 LOCAL FUNDS	1001032-CHIEF OPERATING OFFICE	70489-CHIEF OPERATING OFFICER, ADMINISTRATIVE FUNCTIONS (HT0)	711100C-OTHER SERVICES & CHARGES	\$4,397
			1010001-LOCAL FUNDS							1010001-LOCAL FUNDS	No Project	No Award	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV1 (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,155,000
Reprogramming Adjustment 2	\$760,000.00	The purpose of this reprogramming was to align the District of Columbia Access System (DCAS) budget to support system changes and upgrades, as approved by the Implementation Advanced Planning Document (IAPD), within CSG 40 (Contractual Services).	3030300-LONG TERM / G.O. / LT. BONDS	100471 - 06.01 - P00401-03100 PHARMACY BENEFITS SYSTEM REFRESH CLAIMS MANAGEMENT	3000099 - HT0.0300 CAPITAL FUND OTHER	700087-CLAIMS PROCESSING & QUALITY ASSURANCE-CONTROL	70264-DIVISION OF CLAIMS MANAGEMENT (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$150,000	3030304-SHORT - TERM BONDS	100488 - 06.37 - DCAS-MODERN DC ACCESS SYSTEM - LOCAL INFORMATION TECHNOLOGY	3000103 - HT0.0304 SHORT TERM BONDS	700079-E & E SYSTEMS	70268-INFORMATION TECHNOLOGY DIVISION - HT0 (HT0)	713200C- CONTRACTUAL SERVICES - OTHER	\$760,000
			3030300-LONG TERM / G.O. / LT. BONDS	100472 - 06.01 - P00401-03100 PROVIDER DATA MANAGEM SYS REFRESH CLAIMS MANAGEMENT	3000099 - HT0.0300 CAPITAL FUND OTHER	700087-CLAIMS PROCESSING & QUALITY ASSURANCE-CONTROL	70264-DIVISION OF CLAIMS MANAGEMENT (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$1,400,000							

Reprogramming Adjustment 4	\$25,759,290.00	The purpose of this reprogramming was to align the HCBS ARPA funds to the anticipated expenditures. HCBS ARPA budget was loaded in the incorrect programs and Cost Centers, within in CSG 50 (MEDICAL VENDOR SERVICES).	1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201757 - 10.01 - LTSS Referral Management System	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700554-HCBS ARPA BENEFICIARY EDUCATION AND SUPPORT	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$13,770	1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201741 - 10.15 - DSP Living Wage Increase (DSP Enhanced Living Wage Supplemental)	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700548-HCBS ARPA ENHANCED WAGE SUPPLEMENTAL	7020-PERSONAL CARE SERVICES (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$12,405,254
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	401066 - 10.06 - DDS Stakeholder Technical Assistance	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700550-HCBS ARPA INITIATIVES (DDS)	70055-DDS HCBS ADMINISTRATIVE (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$16,837	1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201741 - 10.04 - DSP Living Wage Increase (DSP Enhanced Living Wage Supplemental)	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700548-HCBS ARPA ENHANCED WAGE SUPPLEMENTAL	7028-IDD WAIVER (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$6,468,674
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201737 - 10.01 - DDS Housing Coordinator	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700550-HCBS ARPA INITIATIVES (DDS)	70055-DDS HCBS ADMINISTRATIVE (HT0)	701200C-CONTINUING FULL TIME - OTHERS	\$126,827	1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201758 - 10.01 - MBRS Rate Inflation	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700547-HCBS ARPA PROVIDER PAYMENTS	7018-CLINIC SERVICES - MBRS (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$4,689,815
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201737 - 10.01 - DDS Housing Coordinator	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700550-HCBS ARPA INITIATIVES (DDS)	70055-DDS HCBS ADMINISTRATIVE (HT0)	701400C-FRINGE BENEFITS - CURR PERSONNEL	\$127,822	1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201788 - 10.01 - Electronic Health Records (EHR) Incentive (HCBS PFP) Digital T	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700553-HCBS ARPA QUALITY OVERSIGHT & PROVIDER CAPACITY	7004-HCBS ARPA HCRIA INITIATIVES (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$131,500
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201744 - 10.01 - Direct Care Worker Training - Materials	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700549-HCBS ARPA WORKFORCE INCENTIVES AND PROVIDER REIMBU	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$170,000	1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201721 - 10.01 - 1915(c) JFS Waiver Self-Directed Services	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700547-HCBS ARPA PROVIDER PAYMENTS	7043-JFS WAIVER (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$64,027
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201754 - 10.01 - Increased HCBS Services Oversight	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700555-HCBS ARPA INITIATIVES (DRCF)	70044-HCBS OVERSIGHT & IMPLEMENTATION (HT0)	701400C-FRINGE BENEFITS - CURR PERSONNEL	\$124,800							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	401066 - 10.09 - Rate Study	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700550-HCBS ARPA INITIATIVES (DDS)	70055-DDS HCBS ADMINISTRATIVE (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$127,695							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201725 - 10.01 - Assisted Living Facility (ALF) Study	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700552-HCBS ARPA EXPANSION OF SERVICE AND ACCESS	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$160,152							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201752 - 10.01 - HCBS Telehealth Project - Housing Supportive Services (HSS) pre	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700555-HCBS ARPA INITIATIVES (DRCF)	70054-HCBS ARPA HCRIA INITIATIVES (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$190,000							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201743 - 10.01 - Direct Care Worker Training - Project Manager	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700549-HCBS ARPA WORKFORCE INCENTIVES AND PROVIDER REIMBU	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$161,500							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201734 - 10.01 - DDS Assistive Technology Solution Pilot	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700550-HCBS ARPA INITIATIVES (DDS)	70055-DDS HCBS ADMINISTRATIVE (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$190,000							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201751 - 10.01 - HCBS Social Needs Strategic Plan	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700555-HCBS ARPA INITIATIVES (DRCF)	70054-HCBS ARPA HCRIA INITIATIVES (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$192,500							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201763 - 10.01 - Remote Patient Monitoring Pilot	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700552-HCBS ARPA EXPANSION OF SERVICE AND ACCESS	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$194,514							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201735 - 10.01 - DDS Behavioral Health Initiative	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700550-HCBS ARPA INITIATIVES (DDS)	70055-DDS HCBS ADMINISTRATIVE (HT0)	713200C-CONTRACTUAL SERVICES - OTHER	\$140,000							
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201722 - 10.01 - ARPA Implementation and Administrative Oversight	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	700555-HCBS ARPA INITIATIVES (DRCF)	70044-HCBS OVERSIGHT & IMPLEMENTATION (HT0)	701400C-FRINGE BENEFITS - CURR PERSONNEL	\$179,300							

			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201759 - 10.01 - PASSR Implementation - Review - Electronic Form Database	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70055-HCBS ARPA INITIATIVES (DRCF)	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	71200C-CONTRACTUAL SERVICES - OTHER	\$130,000	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201726 - 10.01 - Associate Medical Director	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70055-HCBS ARPA INITIATIVES (DRCF)	70049-HCBS OVERSIGHT & IMPLEMENTATION (HT0)	701200C-CONTINUING FULL TIME - OTHERS	\$130,000	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201753 - 10.01 - Home Health Rate Study	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70055-HCBS ARPA INITIATIVES (DRCF)	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	71200C-CONTRACTUAL SERVICES - OTHER	\$412,500	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201760 - 10.01 - Quality Management Contractor - QMC Coordinator	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70053-HCBS ARPA QUALITY OVERSIGHT & PROVIDER CAPACITY	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	71200C-CONTRACTUAL SERVICES - OTHER	\$418,303	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201774 - 10.01 - Increased HCBS Services Oversight	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70055-HCBS ARPA INITIATIVES (DRCF)	70049-HCBS OVERSIGHT & IMPLEMENTATION (HT0)	701200C-CONTINUING FULL TIME - OTHERS	\$443,231	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201724 - 10.01 - ASARS Rate Inflation	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70047-HCBS ARPA PROVIDER PAYMENTS	70234-APLA ASARS ADULT SUBSTANCE ABUSE (HT0)	71400C-GOVERNMENT SUBSIDIES & GRANTS	\$139,430	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	400666 - 10.10 - Remote Support/Enabling Technology	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70050-HCBS ARPA INITIATIVES (DDS)	70053-DDS HCBS ADMINISTRATIVE (HT0)	71200C-CONTRACTUAL SERVICES - OTHER	\$175,866	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201750 - 10.01 - Clinical Case Management System Enhancements	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70053-HCBS ARPA QUALITY OVERSIGHT & PROVIDER CAPACITY	70055-HCBS ARPA LTC IMPROVEMENTS (HT0)	71200C-CONTRACTUAL SERVICES - OTHER	\$123,630	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201722 - 10.01 - ARPA Implementation and Administrative Oversight	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70055-HCBS ARPA INITIATIVES (DRCF)	70049-HCBS OVERSIGHT & IMPLEMENTATION (HT0)	701200C-CONTINUING FULL TIME - OTHERS	\$162,905	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201749 - 10.01 - HCBS EHR and Telehealth Project (Digital TA) Grant	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70053-HCBS ARPA QUALITY OVERSIGHT & PROVIDER CAPACITY	70054-HCBS ARPA HCRA INITIATIVES (HT0)	71400C-GOVERNMENT SUBSIDIES & GRANTS	\$1,035,017	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201765 - 10.02 - Retention Bonus	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70049-HCBS ARPA WORKFORCE INCENTIVES AND PROVIDER REIMBU	70228-IDD WAIVER (HT0)	71400C-GOVERNMENT SUBSIDIES & GRANTS	\$1,395,303	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201746 - 10.02 - Direct Care Worker Vaccination Incentive	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70049-HCBS ARPA WORKFORCE INCENTIVES AND PROVIDER REIMBU	70228-IDD WAIVER (HT0)	71400C-GOVERNMENT SUBSIDIES & GRANTS	\$2,145,762	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201753 - 10.01 - Innovative Programs, Pilot, or Studies	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70052-HCBS ARPA EXPANSION OF SERVICE AND ACCESS	70049-HCBS OVERSIGHT & IMPLEMENTATION (HT0)	71200C-CONTRACTUAL SERVICES - OTHER	\$4,902,826	
			1010208-THE MEDICAID HCBS ENHANCEMENT FUND	201762 - 10.02 - Recruitment and Conversion Bonus	2001259 - HT0.1125 THE MEDICAID HCBS ENHANCEMENT FUND	70049-HCBS ARPA WORKFORCE INCENTIVES AND PROVIDER REIMBU	70228-IDD WAIVER (HT0)	71400C-GOVERNMENT SUBSIDIES & GRANTS	\$1,967,874	

Grant Reprogramming Adjustment 1	\$1,70,000.00	The funds were needed to align the HCRIA and RTS budgets authority with the projected expenditures.	4025002-FEDERAL MEDICAID PAYMENTS	200873 - 23.03 - AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION	2001983 - HT0 K250 MAM023 MEDICAID INFORMATION EXCHANGE MES ENTITLEMENT	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,125,000.00	4025002-FEDERAL MEDICAID PAYMENTS	200881 - 25.20 - AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV (HTF)	713200C-CONTRACTUAL SERVICES & OTHER	\$180,000.00
			4025002-FEDERAL MEDICAID PAYMENTS	200881 - 25.22 - INFORMATION TECHNOLOGY DIVISION (HTF) INFORMATION TECHNOLOGY	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	100071-INFORMATION TECHNOLOGY SERVICES - GENERAL	70266-INFORMATION TECHNOLOGY DIVISION - (HTF) (HTF)	713200C-CONTRACTUAL SERVICES - OTHER	\$1,45,000.00	4025002-FEDERAL MEDICAID PAYMENTS	402862 - 10.02 - T00 DC Nt	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	100142-CHIEF OPERATING OFFICE	70409-CHIEF OPERATING OFFICE, ADMINISTRATIVE FUNCTIONS (HTF)	713300C-OTHER SERVICES & CHARGES	\$45,000.00
				200877 - 23.03 - AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION	2001983 - HT0 K250 MAM023 MEDICAID INFORMATION EXCHANGE MES	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS		4025002-FEDERAL MEDICAID PAYMENTS	200881 - 25.20 - AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIVISION	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$945,000.00
Grant Reprogramming Adjustment 2	\$493,400.00	The purpose of this reprogramming was to align budget authority with anticipated expenditures for the Money Follows the Person (MFP) grant to support licensing infrastructure and management platforms for healthcare professionals for the Inter-Agency project with the Department of Health (DOH).	4025002-FEDERAL GRANTS	402857 - 16.01 - MFP MOU Capacity Building Grant	2006712 - HT0 K250 MAM023 MEDICAID INFORMATION EXCHANGE MES FOLLOWS THE PERSON	100193-OPERATIONS	70272-LONG TERM CARE OPERATIONS DIVISION (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,993,400.00	4025002-FEDERAL GRANTS	402857 - 16.01 - MFP MOU Capacity Building Grant	2006712 - HT0 K250 MAM023 MEDICAID INFORMATION EXCHANGE MES FOLLOWS THE PERSON	100193-OPERATIONS	70272-LONG TERM CARE OPERATIONS DIVISION (HTF)	717000C-PURCHASES EQUIPMENT & MACHINERY	\$493,400.00
Grant Reprogramming Adjustment 3	\$98,526.79	The purpose of this reprogramming was to align the medical budget (Linkage and Tracking MOU) with the anticipated expenditures.	4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.01 - DSH/LINKAGE CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S H	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	700094-QUALITY & HEALTH OUTCOMES	70163-DIVISION OF CHILDREN'S HEALTH SERVICES	70400C-FRIDGE BENEFITS - CURR PERSONNEL	\$1,091,877.00	4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.01 - DSH/LINKAGE CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S H	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	700094-QUALITY & HEALTH OUTCOMES	70163-DIVISION OF CHILDREN'S HEALTH SERVICES (HTF)	70200C-CONTINUING FULL TIME - OTHERS	\$1,81,877.00
			4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.02 - CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S HEALTH SERVICE	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	100188-CHILDREN'S HEALTH SERVICES	70163-DIVISION OF CHILDREN'S HEALTH SERVICES (HTF)	713100C-OTHER SERVICES & CHARGES	\$1,36,500.00	4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.02 - CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S HEALTH SERVICE	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	100188-CHILDREN'S HEALTH SERVICES	70163-DIVISION OF CHILDREN'S HEALTH SERVICES (HTF)	713100C-OTHER SERVICES & CHARGES	\$2,250.00
				400518 - 23.02 - CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S HEALTH SERVICE	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	100188-CHILDREN'S HEALTH SERVICES	70163-DIVISION OF CHILDREN'S HEALTH SERVICES (HTF)	713100C-OTHER SERVICES & CHARGES		4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.02 - CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S HEALTH SERVICE	2001984 - HT0 K250 MAM023 MEDICAID ADMIN ENTITLEMENT	100188-CHILDREN'S HEALTH SERVICES	70163-DIVISION OF CHILDREN'S HEALTH SERVICES (HTF)	713100C-OTHER SERVICES & CHARGES	\$14,400.00
Grant Reprogramming Adjustment 4	\$6,000.00	The purpose of this reprogramming was to support the Home & Community-Based Services Conference reprogramming of \$6,000.00. This request was necessary for the Money Follows the Person (MFP) grant to support travel and conference fees within the Department of Health Care Finance (DHCF).	4025002-FEDERAL GRANTS	200870 - 16.01 - 6AMFP L1000.MONEY FOLLOWS THE PERSON GRANT LONG TERM CARE SUPPO	2006712 - HT0 K250 MAM023 MEDICAID INFORMATION EXCHANGE MES FOLLOWS THE PERSON	700093-PROVIDER OVERSIGHT	70270-LONG TERM CARE SUPPORT SERVICES DIVISION (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$6,000.00	4025002-FEDERAL GRANTS	200884 - 25.06 - LONG TERM CARE OPERATIONS DIVISION	2006712 - HT0 K250 MAM023 MEDICAID INFORMATION EXCHANGE MES FOLLOWS THE PERSON	100193-OPERATIONS	70272-LONG TERM CARE OPERATIONS DIVISION (HTF)	713100C-OTHER SERVICES & CHARGES	\$4,000.00
				200870 - 16.02 - 6AMFP L1000.MONEY FOLLOWS THE PERSON GRANT LONG TERM CARE SUPPO	2006712 - HT0 K250 MAM023 MEDICAID INFORMATION EXCHANGE MES FOLLOWS THE PERSON	100193-OPERATIONS	70272-LONG TERM CARE OPERATIONS DIVISION (HTF)	713100C-OTHER SERVICES & CHARGES		4025002-FEDERAL GRANTS	200870 - 16.02 - 6AMFP L1000.MONEY FOLLOWS THE PERSON GRANT LONG TERM CARE SUPPO	2006712 - HT0 K250 MAM023 MEDICAID INFORMATION EXCHANGE MES FOLLOWS THE PERSON	100193-OPERATIONS	70272-LONG TERM CARE OPERATIONS DIVISION (HTF)	713100C-OTHER SERVICES & CHARGES	\$2,000.00
Grant Reprogramming Adjustment 6	\$231,309,200.00	The purpose of this reprogramming was to align budget within the Medicaid Provider Payment services with anticipated expenditures.	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.08 - F2513 F25H DSH DENTAL OPTION DSH DENTAL OPTION	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70102-DSH - DENTAL OPTION (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,7,300.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.08 - F2513 F25H DSH DENTAL OPTION DSH DENTAL OPTION	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70102-DSH - DENTAL OPTION (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$128,300.00
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.29 - F2504 F25H PHYSICAL THERAPY F25H PHYSICAL THERAPY	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70210-PHYSICAL THERAPY (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,36,500.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.29 - F2504 F25H PHYSICAL THERAPY F25H PHYSICAL THERAPY	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70210-PHYSICAL THERAPY (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$46,100,000.00
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.13 - F2402 F24H OTHER PRACTITIONER SERVICES MEDICAID/OTHER PRAC	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70102-OTHER PRACTITIONER SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,11,000.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.13 - F2402 F24H OTHER PRACTITIONER SERVICES MEDICAID/OTHER PRAC	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70102-OTHER PRACTITIONER SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$28,910,000.00
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.20 - F2740 F274H EPDST MEDICAID/EPDST MEDICAID	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70102-EPDST-MEDICAID (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,30,000.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.21 - F2740 F274H EPDST MEDICAID/EPDST MEDICAID	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70102-EPDST-MEDICAID (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$20,820,000.00
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.12 - F2240 F224H DENTAL SERVICES DSH DENTAL SERVICES	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70102-DENTAL SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,65,900.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.12 - F2240 F224H DENTAL SERVICES DSH DENTAL SERVICES	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70102-DENTAL SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$9,439,200.00
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.09 - F2154 F215H PHYSICIAN SERVICES MEDICAID/PHYSICIAN SERVICES MG	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70114-PHYSICIAN SERVICES-MEDICAID (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,103,000.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.09 - F2154 F215H PHYSICIAN SERVICES MEDICAID/PHYSICIAN SERVICES MG	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70114-PHYSICIAN SERVICES-MEDICAID (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.30 - F2430 F243H PROSTHETIC DEVICES/PROSTHETIC DEVICES MEDICAID/PROSTHETIC	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70212-PROSTHETIC DEVICES, DENTURES, FYRGLASSES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,117,000.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.30 - F2430 F243H PROSTHETIC DEVICES/PROSTHETIC DEVICES MEDICAID/PROSTHETIC	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70212-PROSTHETIC DEVICES, DENTURES, FYRGLASSES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.46 - F2104 F210H HEALTH HOMES I MEDICAID/HEALTH HOMES I	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70217-HEALTH HOMES I (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,218,400.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.46 - F2104 F210H HEALTH HOMES I MEDICAID/HEALTH HOMES I	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70217-HEALTH HOMES I (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.55 - F2102 F210H MON. MEDICAID/DOLLA SERVICES MON. MEDICAID/DOLLA SERV	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70201-DOLLA SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,91,600.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.55 - F2102 F210H MON. MEDICAID/DOLLA SERVICES MON. MEDICAID/DOLLA SERV	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70201-DOLLA SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.56 - F2103 F210H DSNP MEDICAID/DSNP	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70203-DUAL CHOICE (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,430,000.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.56 - F2103 F210H DSNP MEDICAID/DSNP	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70203-DUAL CHOICE (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.06 - F2740 F274H PSYCHIATRIC RESIDENT TREAT. MEDICAID/PSYCHIATRIC	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70219-PSYCHIATRIC RESIDENTIAL TREATMENT FACIL. (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,519,600.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.06 - F2740 F274H PSYCHIATRIC RESIDENT TREAT. MEDICAID/PSYCHIATRIC	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70219-PSYCHIATRIC RESIDENTIAL TREATMENT FACIL. (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.14 - F2240 F224H PRIVATE DUTY NURSING MEDICAID/PRIVATE DUTY NURSE	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70218-PRIVATE DUTY NURSING (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,405,100.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.14 - F2240 F224H PRIVATE DUTY NURSING MEDICAID/PRIVATE DUTY NURSE	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70218-PRIVATE DUTY NURSING (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.25 - F2104 F210H PERSONAL CARE SERVICES MEDICAID/PERSONAL CARE SER	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70203-PERSONAL CARE SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,913,300.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.25 - F2104 F210H PERSONAL CARE SERVICES MEDICAID/PERSONAL CARE SER	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70203-PERSONAL CARE SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.43 - F2104 F210H APRS ASARS-ADULT SUBSTANCE ABUSE MEDICAID/APRS ASARS	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70214-APRS ASARS-ADULT SUBSTANCE ABUSE (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,103,000.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.43 - F2104 F210H APRS ASARS-ADULT SUBSTANCE ABUSE MEDICAID/APRS ASARS	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70214-APRS ASARS-ADULT SUBSTANCE ABUSE (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	
			4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.04 - F2104 F210H MENTAL HEALTH FACILITY SERV MEDICAID/MENTAL HEAL	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70104-MENTAL HEALTH FACILITY SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$1,260,000.00	4025002-FEDERAL MEDICAID PAYMENTS	200883 - 23.04 - F2104 F210H MENTAL HEALTH FACILITY SERV MEDICAID/MENTAL HEAL	2001980 - HT0 K250 MAM023 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FFS - MEDICAID	70104-MENTAL HEALTH FACILITY SERVICES (HTF)	714100C-GOVERNMENT SUBSIDIES & GRANTS	

4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.27 - F73M03.F010.FEDERALLY- QUALIFIED HEALTHCTR (MEDIC.)-FEDERALLY-Q	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FTS - MEDICAID	70204-FEDERALLY- QUALIFIED HEALTH CENTER (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (1,272,200)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.39 - F70M03.F090.ADLT DAY MEDICAID, ADULT DAY SERVICES	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FTS - MEDICAID	70210-ADULT DAY HEALTH (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (1,397,400)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.22 - F40M03.F040.MEDICAID PART B (MEDICAID), MEDICAID PART B	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FTS - MEDICAID	70108-MEDICAID PART B (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (2,900,000)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.18 - F34M03.F040.HOME HEALTH SERVICES (MEDICAID), HOME HEALTH SERVICE	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FTS - MEDICAID	70102-HOME HEALTH SERVICES (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (4,689,100)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.28 - F32M03.F030.NON- EMERGENCY MEDICAL TRANSPORT (MEDIC.)-NON-EMERGE	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FTS - MEDICAID	70208-NON-EMERGENCY MEDICAL TRANSPORTATION (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (5,709,400)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.45 - F90M03.F090.MCO - EXPANSION POPULATION (HT0) FFP, MCO - EXPANSI	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700102-MCO - CHILDLESS ADULTS (GROUP B)	70214-MCO- EXPANSION POPULATION (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (6,266,200)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.48 - F74M03.F040.PCM FOR ALL INCLUSIVE CARE (PACE) - MED PROGRAM OF	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FTS - MEDICAID	70209 PROGRAM OF ALL- INCLUSIVE CARE (PACE) (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (6,639,900)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.23 - F42M03.F020.MANAGED CARE ORGANIZATIONS- MCO (MEDIC.)-MANAGED CA	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700105-MCO - MEDICAID	70206-MANAGED CARE ORGANIZATIONS (MCO) (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (9,958,800)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.08 - F72M03.F020.CFMR PRIVATE (MEDICAID), CFMR PRIVATE	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FTS - MEDICAID	70173-CF PRIVATE (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (10,152,900)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.24 - F44M03.F040.HBCSN (MEDICAID), HBCSN	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700105-MCO - MEDICAID	70202-CASSIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (12,694,200)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.59 - F01C3.F010.EMERGENCY MEDICAID-GROUP VIII (MEDICAID), EMERGENC Y	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700008-FTS - CHILDLESS ADULTS (GROUP B)	70499-EMERGENCY MEDICAID GROUP VIII (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (13,362,000)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.15 - F20M03.F020.CLINIC SERVICES - MENTAL HEALTH (MED.), CLINIC SERV	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700100-FTS - MEDICAID	70106-CLINIC SERVICES - MENTAL HEALTH (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (16,179,200)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.37 - F80M03.F080.MR/DD WAVES (MEDICAID), MR/DD WAVES	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700097-11151915 - MEDICAID	70229-IDD WAIVER (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (17,461,800)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.51 - F01M03.F010.Permanen t Supportive Housing Group VIII Permanent S	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700008-FTS - CHILDLESS ADULTS (GROUP B)	70402-PERMANENT SUPPORTIVE HOUSING- GROUP VIII (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (17,696,500)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.57 - F01M3.F010.DSNP NON- FFD, DSNP NON-FFD	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700105-MCO - MEDICAID	70407-DEAL CHOICE (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (20,626,100)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.50 - F40M03.F040.MCO - ABD, MCO - ABD	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700105-MCO - MEDICAID	70500-MCO-ABD (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (31,068,000)
4025002-FEDERAL MEDICAID PAYMENTS	200083 - 23.40 - F70M03.F010.NEWLY ELIGIBLE (MEDICAID), NEWLY ELIGIBLE	2001900 - HT0.K250.M0MD25 MEDICAID MEDICAL ASSISTANCE PAYMEN	700102-MCO - CHILDLESS ADULTS (GROUP B)	70231-MCO-NEWLY ELIGIBLE (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (47,000,000)

Grant Reprogramming Adjustment 7	\$5,528,300.00	The purpose of this reprogramming was to align budget authority with anticipated expenditures in the Medicaid CHIP programs within several services in CSG 50 (MEDICAL VENDOR SERVICES).	4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.22 - 800CC.F5010.DC CHARTER SCHOOLS (CHIP).DC.CHARTER SCHOOLS - CHIP	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70047-DC.CHARTER SCHOOLS - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (5,000,000)	4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.09 - F13CC.F0330.CLINIC SERVICES - MBRS (CHIP).CLINIC SERVICES - MBR	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70189-CLINIC SERVICES - MBRS CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$2,902,000
			4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.14 - F25CC.F0200.FEDERALLY QUALIFIED HEALTHCTR (CHIP).FEDERALLY-QUA	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70207-FEDERALLY- QUALIFIED HEALTH CENTER - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (443,300)	4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.28 - DC.Fac & EMS Services - CHIP	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70256-FIRE & EMS SVS (AMBUCLANCE) - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$969,000
			4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.13 - F40CC.F0600.MANAGED CARE ORGANIZATIONS (MCO) (CHIP).MANAGED CAR	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700103-MCO - CHIP	70201-MANAGED CARE ORGANIZATIONS (MCO) - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (400,000)	4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.01 - F10CC.F0620.INPATIENT (CHIP).INPATIENT CHIP	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70165-INPATIENT CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$307,000
			4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.23 - 800CC.F5050.OSSE- CHILDREN W/SPCL NEEDS TRNSPT (CHIP).OSSE-CHILD	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70249-OSSE-CHILDREN W/SPCL NEEDS TRNSPT - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (706,000)	4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.26 - F40CC.F4400.HSCSN (CHIP).HSCSN - CHIP	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700103-MCO - CHIP	70242-CASSIP - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$445,000
			4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.04 - F23CC.F0210.PRESCRIBE D DRUGS - CHIP.PRESCRIBED DRUGS - CHIP	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70179-PRESCRIBED DRUGS CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (1,400,000)	4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.06 - F25CC.F0200.OTHER PRACTITIONERS' SERVICES (CHIP).OTHER PRACTITI	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70183-OTHER PRACTITIONERS' SERVICES CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$176,000
			4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.21 - 800CZ.F5010.DC.PUBLIC SCHOOLS (CHIP).DC PUBLIC SCHOOLS - CHIP	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70245-DC PUBLIC SCHOOLS CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$ (2,300,000)	4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.25 - F40CC.F4670.PSYCHIATRIC RESIDENTIAL TREATMENT -CHIP.PSYCHIATRI	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70456.PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$167,000
										4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.03 - F19CC.F0300.OUTPATIENT HOSPITAL CHIP. OUTPATIENT HOSPITAL CHIP	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70177-OUTPATIENT HOSPITAL CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$137,000
										4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.05 - F23CC.F0230.DENTAL SERVICES (CHIP).DENTAL SERVICES - CHIP	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70181-DENTAL SERVICES - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$82,600
										4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.18 - F67CC.F0670.EMERGENCY HOSPITAL SERVICES (CHIP).EMERGENCY HOSPT	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70216-EMERGENCY HOSPITAL SERVICES - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$70,000
										4025002-FEDERAL MEDICIAD PAYMENTS	200875 - 23.10 - F33CC.F0330.LABORATORY & RADIOLOGICAL SERVICE (CHIP).LABORATORY	2001981 - HT0.MCIP32.CHILDRENS HEALTH INSURANCE PROGRAM CHIP	70009.FFS - CHIP	70191-LABORATORY & RADIOLOGICAL SERVICES - CHIP (HT0)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$29,400

										4025002-FEDERAL MEDICAID PAYMENTS	200875 - 23.02 - F16CC F1640 PHYSICIAN SERVICES (CHIP) PHYSICIAN SERVICES CHIP	2001981 - H16A MCP32 CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700099.FFS - CHIP	70175-PHYSICIAN SERVICES CHIP (HTD)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$21,000
										4025002-FEDERAL MEDICAID PAYMENTS	200875 - 23.27 - DM8 Rehab Program - CHIP	2001981 - H16A MCP32 CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700099.FFS - CHIP	70251-DM8 - REHAB OPTION - CHIP (HTD)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$11,600
										4025002-FEDERAL MEDICAID PAYMENTS	200875 - 23.17 - F05CC F0630 PROSTHETIC DVSX,DENTURES,EYEGLASS (CHIP) PROSTHETIC D	2001981 - H16A MCP32 CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700099.FFS - CHIP	70213-PROSTHETIC DVSX,DENTURES,EYEGLASS S-CHIP (HTD)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$3,200
										4025002-FEDERAL MEDICAID PAYMENTS	200875 - 23.07 - F27CC F0270 CLINIC SERVICES - PRIVATE (CHIP) CLINIC SERVICES -	2001981 - H16A MCP32 CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700099.FFS - CHIP	70185-CLINIC SERVICES - PRIVATE CHIP (HTD)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$2,700
										4025002-FEDERAL MEDICAID PAYMENTS	200875 - 23.08 - F29CC F0290 CLINIC SERVICES - MENTAL HEALTH (CHIP) CLINIC SERV	2001981 - H16A MCP32 CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700099.FFS - CHIP	70187-CLINIC SERVICES - MENTAL HEALTH CHIP (HTD)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$2,300
										4025002-FEDERAL MEDICAID PAYMENTS	200875 - 23.16 - F56CC F0560 PHYSICAL THERAPY (CHIP) PHYSICAL THERAPY - CHIP	2001981 - H16A MCP32 CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700099.FFS - CHIP	70211-PHYSICAL THERAPY - CHIP (HTD)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$300
										4025002-FEDERAL MEDICAID PAYMENTS	200875 - 23.20 - F77CC F0770 DURABLE MED EQUIP (DM8) MEDICAID (CHIP) DURABLE MED	2001981 - H16A MCP32 CHILDRENS HEALTH INSURANCE PROGRAM CHIP	700099.FFS - CHIP	70222-DURABLE MED EQUIP (DM8) MEDICAID - CHIP (HTD)	714100C-GOVERNMENT SUBSIDIES & GRANTS	\$300
																\$244,618,874

Request	Request Amount	Description/Justification	Fund		Project	Award	Program	Account	Amount	Fund	Project	Award	Program	Account	Amount	
Grant Reprogramming Adjustment 1	\$394,778.00	The purpose of this reprogramming was to align the Medicaid FY20 PS budget (Lumpsum and Tracking MED) with the anticipated expenditures.	4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.01 - DWSA3.D0500 CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S H	2002472 - HTU0MAAD26/MEDICAID ADMIN ENTITLEMENT	700094-QUALITY & HEALTH OUTCOMES	70165-DIVISION OF CHILDREN'S HEALTH SERVICES (HT0)	701400C-FRINGE BENEFITS - CURR PERSONNEL	\$ (75,559)	4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.02 - CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S HEALTH SERV	2002472 - HTU0MAAD26/MEDICAID ADMIN ENTITLEMENT	000188-CHILDREN'S HEALTH SERVICES	70165-DIVISION OF CHILDREN'S HEALTH SERVICES (HT0)	701400C-FRINGE BENEFITS - CURR PERSONNEL	\$75,559
			4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.01 - DWSA3.D0500 CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S H	2002472 - HTU0MAAD26/MEDICAID ADMIN ENTITLEMENT	700094-QUALITY & HEALTH OUTCOMES	70165-DIVISION OF CHILDREN'S HEALTH SERVICES (HT0)	701200C-CONTINUING FULL TIME - OTHERS	\$ (157,715)	4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.02 - CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S HEALTH SERV	2002472 - HTU0MAAD26/MEDICAID ADMIN ENTITLEMENT	000188-CHILDREN'S HEALTH SERVICES	70165-DIVISION OF CHILDREN'S HEALTH SERVICES (HT0)	701200C-CONTINUING FULL TIME - OTHERS	\$157,715
			4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.01 - DWSA3.D0500 CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S H	2002472 - HTU0MAAD26/MEDICAID ADMIN ENTITLEMENT	700094-QUALITY & HEALTH OUTCOMES	70165-DIVISION OF CHILDREN'S HEALTH SERVICES (HT0)	701100C-CONTINUING FULL TIME	\$ (163,504)	4025002-FEDERAL MEDICAID PAYMENTS	400518 - 23.02 - CHILDREN'S HEALTH SERVICES (MED ADMIN) CHILDREN'S HEALTH SERV	2002472 - HTU0MAAD26/MEDICAID ADMIN ENTITLEMENT	000188-CHILDREN'S HEALTH SERVICES	70165-DIVISION OF CHILDREN'S HEALTH SERVICES (HT0)	701100C-CONTINUING FULL TIME	\$163,504
Grant Reprogramming Adjustment 2	\$300,000.00	This reprogramming was necessary for the "Promote Continuity of Care Following Incarceration grant" to support Personnel Services and Contractual Services.	4020002-FEDERAL GRANTS	203223 - 25.02 - Affordable Care Reform and Grants Development Division	2002811 - HT0-Continuity of Care Following Incarceration Gra	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV1 (HT0)	717100C-PURCHASES EQUIPMENT & MACHINERY	\$ (300,000)	4020002-FEDERAL GRANTS	203223 - 26.01 - Grant Period 10/1/2025 - 6/30/2026	2002811 - HT0-Continuity of Care Following Incarceration Gra	000197-ELIGIBILITY POLICY & OVERSIGHT	70534-ELIGIBILITY DETERMINATION (HT0)	701200C-CONTINUING FULL TIME - OTHERS	\$142,779
			4020002-FEDERAL GRANTS	203223 - 25.02 - Affordable Care Reform and Grants Development Division	2002811 - HT0-Continuity of Care Following Incarceration Gra	100207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV1 (HT0)			4020002-FEDERAL GRANTS	203223 - 25.02 - Affordable Care Reform and Grants Development Division	2002811 - HT0-Continuity of Care Following Incarceration Gra	000207-GRANTS ADMINISTRATION FUNCTION	70267-AFFORDABLE CARE REFORM AND GRANTS DEVELOPMENT DIV1 (HT0)	712280C- CONTRACTUAL SERVICES - OTHER	\$121,432
			4020002-FEDERAL GRANTS	203223 - 26.01 - Grant Period 10/1/2025 - 6/30/2026	2002811 - HT0-Continuity of Care Following Incarceration Gra	000197-ELIGIBILITY POLICY & OVERSIGHT	70534-ELIGIBILITY DETERMINATION (HT0)			4020002-FEDERAL GRANTS	203223 - 26.01 - Grant Period 10/1/2025 - 6/30/2026	2002811 - HT0-Continuity of Care Following Incarceration Gra	000197-ELIGIBILITY POLICY & OVERSIGHT	70534-ELIGIBILITY DETERMINATION (HT0)	701400C-FRINGE BENEFITS - CURR PERSONNEL	\$35,829

\$694,778

11. Please provide a complete accounting of all reprogramming received by or transferred from the agency in FY 2025 and FY 2026, to date.

- a. **Provide a complete accounting of all reprogramming within the agency in FY 2025 and FY 2026, to date.**
- b. **For each reprogramming, please provide a narrative description as to the purpose of the transfer and which fund detail, programs, cost center, and account within the agency the reprogramming affected.**

Response:

Please see Q11 – attachment 1.

- 12. Please provide the following information for grants/sub-grants awarded to and by the agency in FY 205 and FY 2026, to date, broken down by program and cost center:**
- 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;**
 - l. Agency employee responsible for grant deliverables; and**
 - m. Any grants where the funds have been reduced or zeroed out in FY 2026, and the amount of the reduction; and**
 - n. For grants/subgrants over \$2M in local dollars awarded by the agency in FY 2025 or FY 2026, please provide the grant agreement to the Committee.**

Response:

Please see Attachment 1 to Q12 for the information requested for all grants awarded to DHCF during FY25 and to date in FY26. The current fiscal year expenditures are through the first quarter, December 31, 2025.

- 14. Please provide the following information for all contracts, including modifications, active during FY 2025 and FY 2026, to date, broken down by program and cost center:**
- 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;**
 - l. Agency employee(s) serving as Contract Administrator; and**
 - m. Any grants where the funds have been reduced or zeroed out in FY 2025, and the amount of the reduction.**

Response:

Please refer to Q14-Attachment 1

Department of Health Care Finance (HCF)
FY2025 Performance Overview Hearing Questions 14
Contracts by Program and Cost Center
Fiscal Years 2025 and FY2026

	Program Name	Cost Center	Cost Center Title	Contract Name / Description	Period of Performance	Contract Service Provider	Purpose of Contract	Procurement Method (Bid or Sub Source)	Contract Number	DMCF Employee Responsible for the Contract (CA)	Original Contract Value	Modifications	Funding Source	FY26 Funding Split	FY25 Actuals	FY26 Approved Budget	FY26 Anticipated Cost	FY26 Expenditures thru 12/31/25	COMMENTS
100058	Agency Management Program	70279	Human Resources	Finger Prints & Background Check - DCIR MOU (Compliance Services MOU)	10/12-9/30/25	DCIR	MOU with DCIR			Patia Shorter	1010001	55%	1010001	55%	3,028.82	3,212.66	3,212.66	-	
100058	Agency Management Program	70279	Human Resources	Finger Prints & Background Check - DCIR MOU (Compliance Services MOU)	10/12-9/30/25	DCIR		4025002	45%	4025002	45%	2,478.12	2,628.54	2,628.54	-				
Agency Management Program - Finger Prints & Background Check - DCIR MOU (Compliance Services MOU) - Total															5,506.94	5,841.20	5,841.20	-	
100058	Agency Management Program	70279	Human Resources	Executive Leadership Training MOU	10/125-9/30/26	DCIR	MOU with DCIR			Patia Shorter	1010001	55%	1010001	55%	7,150.00	8,250.00	8,250.00	-	
100058	Agency Management Program	70279	Human Resources	Executive Leadership Training MOU	10/12-9/30/25	DCIR		4025002	45%	4025002	45%	5,850.00	6,750.00	6,750.00	-				
Agency Management Program - Executive Leadership Training MOU - Total															13,000.00	15,000.00	15,000.00	-	
Agency Management Program - Total - HR-Program/Cost Center															18,506.94	20,841.20	20,841.20	-	
100026	Agency Management Program	70281	OCF	FoSelect Tool for Contract Evaluation	10/12-9/30/25	CACI, INC	Proposal Evaluation Tool	Small Purchase		Helen Barbour	1010001	55%	1010001	55%	-	5,500.00	5,500.00	-	
100026	Agency Management Program	70281	OCF	FoSelect Tool for Contract Evaluation	10/12-9/30/25	CACI, INC		4025002	45%	4025002	45%	-	4,500.00	4,500.00	-				
Agency Management Program - FoSelect Tool for Contract Evaluation - Total															-	10,000.00	10,000.00	-	
Agency Management Program - Total - OCF-Program/Cost Center															-	10,000.00	10,000.00	-	
100113	Agency Management Program	70278	OCDO	Agency Wide Printing - Printing services for the agency	10/12-9/30/25	Foremost Advanced	Printing services for the Agency			Helen Barbour	\$113,500.00	0	1010001	55%	61,454.02	172,425.00	172,425.00	-	
100113	Agency Management Program	70278	OCDO	Agency Wide Printing - Printing services for the agency	10/12-9/30/25	Foremost Advanced		DCSS	CW109101	4025002	45%	50,280.56	141,075.00	141,075.00	-				
Agency Management Program - Agency Wide Printing - Printing services for the agency - Total															111,734.58	313,500.00	313,500.00	-	
100113	Agency Management Program	70278	OCDO	DC General Project - Clinical Data Lookup	10/12-9/30/25	Digi Docs Inc	Records Retention	Invitation for Bid (IFB)		Johnny Rossetto	\$1,023,540.00		1010001	55%	862,947.00	350,614.17	350,614.17	57,590.50	
100113	Agency Management Program	70278	OCDO	DC General Project - Clinical Data Lookup	10/12-9/30/25	Digi Docs Inc		4025002	45%	4025002	45%	460,593.00	286,866.14	286,866.14	47,119.50				
Agency Management Program - DC General Project - Clinical Data Lookup - Total															1,823,540.00	637,480.31	637,480.31	104,710.00	
100113	Agency Management Program	70278	OCDO	Document Tagging/Bar-Coding Tracking System	10/12-9/30/25	Avanti	Document Tracking System	Exempt from Competition		Johnny Rossetto	\$137,500.00		1010001	55%	74,468.02	75,625.00	75,625.00	2,932.40	
100113	Agency Management Program	70278	OCDO	Document Tagging/Bar-Coding Tracking System	10/12-9/30/25	Avanti		POT719179	4025002	45%	60,928.38	61,875.00	61,875.00	2,399.40					
Agency Management Program - Document Tagging/Bar-Coding Tracking System - Total															135,396.40	137,500.00	137,500.00	5,332.00	
100113	Agency Management Program	70278	OCDO	Medical Records Storage/Retrieval	10/12-9/30/25	North Capital Partners & A and E Construction	Heavy Construction			Mya Burroughs	\$59,000.00		1010001	55%	5,446.38	29,337.00	29,337.00	-	
100113	Agency Management Program	70278	OCDO	Medical Records Storage/Retrieval	10/12-9/30/25	North Capital Partners & A and E Construction		RFTOP	DCAM-22-CS-RFQ-0016C	4025002	45%	4,456.13	24,003.00	24,003.00	-				
Agency Management Program - Medical Records Storage/Retrieval - Total															9,902.50	53,340.00	53,340.00	-	
100113	Agency Management Program	70278	OCDO	AVID Systems - Temporary Staff Support	10/12-9/30/25	AVID Systems	Temporary Staffing to provide administrative support and records management support			Johnny Rossetto	\$148,800.00		1010001	55%	31,487.50	67,852.80	67,852.80	3,520.00	
100113	Agency Management Program	70278	OCDO	AVID Systems - Temporary Staff Support	10/12-9/30/25	AVID Systems		DCSS	CW9425	4025002	45%	25,762.50	82,931.20	82,931.20	2,880.00				
Agency Management Program - AVID Systems - Temporary Staff Support - Total															57,250.00	150,784.00	150,784.00	6,400.00	
100113	Agency Management Program	70278	OCDO	Water Filter Service - Water Filtration	10/12-9/30/25	Quench	Filters for Water Coolers	Small Purchase		Tyrese Smith	\$7,761.40		1010001	55%	4,614.29	5,500.00	5,500.00	782.63	
100113	Agency Management Program	70278	OCDO	Water Filter Service - Water Filtration	10/12-9/30/25	Quench		POT718096	4025002	45%	3,775.32	4,500.00	4,500.00	640.33					
Agency Management Program - Water Filter Service - Water Filtration - Total															8,389.61	10,000.00	10,000.00	1,422.96	
100113	Agency Management Program	70278	OCDO	Non-lease maintenance and cleaning services for DCAS	10/12-9/30/25	JBG Potomac Creek Association	TBD			TBD	TBD		1010001	55%	-	5,500.00	5,500.00	-	
100113	Agency Management Program	70278	OCDO	Non-lease maintenance and cleaning services for DCAS	10/12-9/30/25	JBG Potomac Creek Association		4025002	45%	4025002	45%	-	4,500.00	4,500.00	-				
Agency Management Program - Non-lease maintenance and cleaning services for DCAS - Total															-	10,000.00	10,000.00	-	
100113	Agency Management Program	70278	OCDO	Construction - General Repairs	10/12-9/30/25	PM&L LLC/A & E Construction General Repairs	Building Renovations			Tyrese Smith	\$200,000.00		1010001	55%	32,163.80	102,463.00	102,463.00	-	
100113	Agency Management Program	70278	OCDO	Construction - General Repairs	10/12-9/30/25	PM&L LLC/A & E Construction General Repairs		Bd	CW119955	4025002	45%	26,314.20	83,997.00	83,997.00	-				
Agency Management Program - A & E Construction - General Repairs - Total															58,478.00	186,460.00	186,460.00	-	
Agency Management Program - Total - Property Maint./Cost Center															1,499,459.09	1,499,264.31	1,499,264.31	117,864.96	
100182	Agency Management Program	70409	OCDO	Overall Agency Risk Assessment	10/12-9/30/26	BIDA Global	Risk Assessment			Monte Brockett	\$251,596.00		1010001	55%	52,573.47	64,325.00	64,325.00	21,603.04	
100182	Agency Management Program	70409	OCDO	Overall Agency Risk Assessment	10/12-9/30/26	BIDA Global		4025002	45%	4025002	45%	41,014.44	52,612.00	52,612.00	18,649.76				
Agency Management Program - Overall Agency Risk Assessment - Total															93,588.33	116,938.00	116,938.00	41,932.80	
100182	Agency Management Program	70409	OCDO	Contractual Services for New Hospital	10/12-9/30/25	Outline	Marketing Services	G&A	CW123913	Larissa Dravos	\$275,000.00		1010001	100%	256,559.48	-	-	-	New Hospital related expenses
Agency Management Program - Contractual Services for New Hospital - Total															256,559.48	-	-	-	
Agency Management Program - Total - OCDO-Program/Cost Center															231,927.61	116,968.00	116,968.00	41,932.80	
Total - OCDO-Program/Cost Center															1,755,143.64	1,647,065.51	1,647,065.51	159,797.76	
100071	Agency Management Program	70280	IT	Copier Leasing	10/12-9/30/25	Canon	Leasing/Maintenance on copiers	Exempt from Competition		Juan Gonzalez	\$208,111.28		1010001	55%	146,820.56	155,636.25	155,636.25	-	
100071	Agency Management Program	70280	IT	Copier Leasing	10/12-9/30/25	Canon		4025002	45%	4025002	45%	120,125.92	127,338.75	127,338.75	-				
Agency Management Program - Copier Leasing - Total															266,946.48	282,975.00	282,975.00	-	
100071	Agency Management Program	70280	IT	Kwik Tag Document Tracking System	10/12-9/30/25	SupexTech	Document Tracking System	Small Purchase		Herbert Massey	\$93,760.00		1010001	55%	11,807.04	54,111.75	54,111.75	-	
100071	Agency Management Program	70280	IT	Kwik Tag Document Tracking System	10/12-9/30/25	SupexTech		4025002	45%	4025002	45%	9,660.31	44,273.25	44,273.25	-				
Agency Management Program - Kwik Tag Document Tracking System - Total															21,467.35	98,385.00	98,385.00	-	
100071	Agency Management Program	70280	IT	PRF Document Management	10/12-9/30/25	DigiDoc	Premium Support Services			Eric Carroll	\$119,967.40		1010001	55%	65,982.07	69,281.17	69,281.17	65,982.07	
100071	Agency Management Program	70280	IT	PRF Document Management	10/12-9/30/25	DigiDoc		DCSS	CW94939	4025002	45%	53,985.33	56,684.40	56,684.40	53,985.33				
Agency Management Program - PRF Document Management - Total															119,967.40	125,965.57	125,965.57	119,967.40	
100071	Agency Management Program	70280	IT	Information Technology - Cloud Consultant - RE2020	10/12-9/30/25	CAI	Temporary Staff	Requirements		Monte Brockett	\$166,489.84		1010001	55%	13,378.11	121,929.32	121,929.32	18,118.01	
100071	Agency Management Program	70280	IT	Information Technology - Cloud Consultant - RE2020	10/12-9/30/25	CAI		4025002	45%	4025002	45%	10,945.73	99,760.36	99,760.36	14,823.83				
Agency Management Program - Information Technology - Cloud Consultant - To Be Hired - Total															24,323.84	221,689.68	221,689.68	32,941.84	
100071	Agency Management Program	70280	IT	Information Technology - Privacy and Security Officer - Robert Kaplan	10/12-9/30/25	CAI	Temporary Staff	Requirements		Monte Brockett	\$133,802.24		1010001	55%	104,957.84	97,990.46	97,990.46	14,167.30	
100071	Agency Management Program	70280	IT	Information Technology - Privacy and Security Officer - Robert Kaplan	10/12-9/30/25	CAI		4025002	45%	4025002	45%	93,777.84	80,174.02	80,174.02	11,991.42				
Agency Management Program - Information Technology - Privacy and Security Officer - Robert Kaplan - Total															198,735.68	178,164.48	178,164.48	25,758.72	
100071	Agency Management Program	70280	IT	IT Support Contractors: Software/Hardware Network - Lorford Lloyd	10/12-9/30/25	CAI	Temporary Staff	Requirements		Juan Gonzalez	\$89,760.00		1010001	55%	82,943.02	71,455.03	71,455.03	5,432.39	
100071	Agency Management Program	70280	IT	IT Support Contractors: Software/Hardware Network - Lorford Lloyd	10/12-9/30/25	CAI		4025002	45%	4025002	45%	73,186.10	58,463.21	58,463.21	4,461.05				
Agency Management Program - IT Support Contractors: Software/Hardware Network - Lorford Lloyd - Total															156,129.12	129,918.24	129,918.24	9,914.44	
100071	Agency Management Program	70280	IT	IT Support Contractors: Software/Hardware Network - Brian Piper	10/12-9/30/25	CAI	Temporary Staff	Requirements		Juan Gonzalez	\$87,785.28		1010001	55%	75,462.48	64,289.81	64,289.81	9,294.91	
100071	Agency Management Program	70280	IT	IT Support Contractors: Software/Hardware Network - Brian Piper	10/12-9/30/25	CAI		4025002	45%	4025002	45%	38,869.63	52,600.75	52,600.75	7,604.93				
Agency Management Program - IT Support Contractors: Software/Hardware Network - Brian Piper - Total															114,332.11	116,890.56	116,890.56	16,899.84	
100071	Agency Management Program	70280	IT	IT Support Contractors: Software/Hardware Network - Albert Kalay	10/12-9/30/25	CAI	Temporary Staff	Requirements		Juan Gonzalez	\$73,363.84		1010001	55%	22,197.96	-	-	-	
100071	Agency Management Program	70280	IT	IT Support Contractors: Software/Hardware Network - Albert Kalay	10/12-9/30/25	CAI		4025002	45%	4025002	45%	18,161.96	-	-	-				

Program Code	Program Name	Cost Center	Cost Center Title	Contract Name / Description	Period of Performance	Contract Service Provider	Purpose of Contract	Procurement Method (Bid or Sole Source)	Contract Number	DMCF Employee Responsible for the Contract (CA)	Original Contract Value	Modifications	Funding Source	FY26 Funding Ytd	FY25 Actual	FY26 Approved Budget	FY26 Anticipated Cost	FY26 Expenditures thru 12/31/25	COMMENTS
	Agency Management Program			IT Support Contractors: Software/Hardware Network - Albert Kaley - Total															
100071	Agency Management Program	76280	IT	Project Management Officer - Corey Lewis	10/1/24-9/30/25	CAI	Temporary Staff	Bid	CW95481	Monie Brockett	\$45,920.00		1010001	55%	47,656.00	96,851.04	96,851.04	14,002.56	
100071	Agency Management Program	76280	IT	Project Management Officer - Corey Lewis	10/1/24-9/30/25	CAI	Temporary Staff						4029002	45%	43,064.00	79,241.76	79,241.76	11,456.64	
	Agency Management Program			Project Management Officer - Corey Lewis: Keith Williams - Total															
100071	Agency Management Program	76280	IT	Software Integration - Sunath Nethi	10/1/24-9/30/25	CAI	Temporary Staff	Requirements	CW95481	Monie Brockett	\$127,578.88		1010001	55%	93,027.34	93,432.77	93,432.77	13,508.35	
100071	Agency Management Program	76280	IT	Software Integration - Sunath Nethi	10/1/24-9/30/25	CAI	Temporary Staff						4029002	45%	76,137.98	76,444.99	76,444.99	11,032.29	
	Agency Management Program			Software Integration - Sunath Nethi - Total															
100071	Agency Management Program	76280	IT	Software Integration - Gebelchew Eyersadine	10/1/24-9/30/25	CAI	Temporary Staff	Requirements	CW95481	Monie Brockett	\$127,264.72		1010001	55%	101,913.92	93,202.69	93,202.69	7,860.47	
100071	Agency Management Program	76280	IT	Software Integration - Gebelchew Eyersadine	10/1/24-9/30/25	CAI	Temporary Staff						4029002	45%	91,024.95	76,256.75	76,256.75	6,431.29	
	Agency Management Program			Software Integration - Gebelchew Eyersadine - Total															
100071	Agency Management Program	76280	IT	Help Desk Manager-Adrian Asea	04/07/25-9/30/25	CAI	N/A	N/A	N/A	Jan Gonzalez	FTE		1010001	55%	13,809.66	53,728.22	53,728.22	1,941.98	
100071	Agency Management Program	76280	IT	Help Desk Manager-Adrian Asea	04/07/25-9/30/25	CAI	N/A	N/A	N/A	Jan Gonzalez	FTE		4029002	45%	11,298.82	43,959.46	43,959.46	1,588.90	
	Agency Management Program			Configuration Manager- Michael Arrington - Total															
100071	Agency Management Program	76280	IT	Windows Server System Admin-Vinay Chilveru	01/13/25-09/30/25	CAI	N/A	N/A	N/A	Jan Gonzalez	FTE		1010001	55%	104,104.00	153,384.00	153,384.00	22,176.00	
100071	Agency Management Program	76280	IT	Windows Server System Admin-Vinay Chilveru	01/13/25-09/30/25	CAI	N/A	N/A	N/A	Jan Gonzalez	FTE		4029002	45%	85,176.00	125,496.00	125,496.00	18,144.00	
	Agency Management Program			System Administrator - Nohk Lee - Total															
100071	Agency Management Program	76280	IT	Staff Augmentation - 4 Positions	10/1/24-9/30/25	CAI	Temporary Staff	Requirements	CW95481	Erik Thomas	\$856,588.00		1010001	55%	471,123.44	992,936.65	992,936.65	57,370.50	
100071	Agency Management Program	76280	IT	Staff Augmentation - 4 Positions	10/1/24-9/30/25	CAI	Temporary Staff						4029002	45%	385,464.64	812,402.71	812,402.71	46,939.50	
	Agency Management Program			OCCTO IT Assistant - Total															
100071	Agency Management Program	76280	IT	Secure Email	10/1/24-9/30/25	App River, LLC	Software	Small Purchase	733167	Herbert Massey	\$	1,017.92	1010001	55%	856,588.00	1,805,339.36	1,805,339.36	184,110.00	
100071	Agency Management Program	76280	IT	Secure Email	10/1/24-9/30/25	App River, LLC	Software						4029002	45%	10,091.32	8,994.09	8,994.09	8,100.00	
	Agency Management Program			Employee Portal Maintenance - OCOO Internet - Total															
100071	Agency Management Program	76280	IT	Employee Portal Maintenance - OCOO Internet	10/1/24-9/30/25	AVID Systems	Employee Engagement Portal	DCSS	CW108812	Erik Thomas	\$226,000.00		1010001	55%	19,988.21	18,000.00	18,000.00	-	
100071	Agency Management Program	76280	IT	Employee Portal Maintenance - OCOO Internet	10/1/24-9/30/25	AVID Systems	Employee Engagement Portal						4029002	45%	-	33,000.00	33,000.00	-	
	Agency Management Program			Employee Portal Maintenance - OCOO Internet - Total															
100071	Agency Management Program	76280	IT	MDW - OCCTO IT Pipeline - MDW	10/1/24-9/30/25	CAI	Temporary Staff	Requirements	CW95481	Jan Gonzalez	\$3,087,650.50		1010001	25%	751,912.63	1,008,984.16	1,008,984.16	119,777.52	Effective January 1, 2025, AVID, V-TECH and IUI resources were transferred under the CAI contract
100071	Agency Management Program	76280	IT	Microsoft Analytic Platform System (APS) Azure Contract	10/1/24-9/30/25	CDW	Microsoft Licenses	Requirements	CW121294	Jan Gonzalez	\$307,615.62		4029002	45%	2,255,377.88	3,055,952.48	3,055,952.48	399,332.56	
	Agency Management Program			Microsoft Licenses - Amazon Systems (AWS) - Total															
100071	Agency Management Program	76280	IT	SAS Office Analytics	10/1/24-9/30/25	Executive Information Systems	Annual Software Maintenance	Exempt	CW114817	Monie Brockett	\$53,629.00		1010001	55%	332,016.74	240,000.00	240,000.00	-	
100071	Agency Management Program	76280	IT	SAS Office Analytics	10/1/24-9/30/25	Executive Information Systems	Annual Software Maintenance						4029002	45%	177,619.21	132,000.00	132,000.00	-	
	Agency Management Program			MDW - Staff Augmentation - MDW - 3 Positions															
100071	Agency Management Program	76280	IT	MDW - Staff Augmentation - MDW - 3 Positions	10/1/24-9/30/25	Avid, IUI and Vtech	Temporary Staff	Competitive	CW95427, CW95428, CW95423	Erik Thomas	\$329,920.00		1010001	25%	82,480.09	15,750.00	15,750.00	-	Effective January 1, 2025, AVID, V-TECH and IUI resources were transferred under the CAI contract
100071	Agency Management Program	76280	IT	MDW - Staff Augmentation - MDW - 1 Position	10/1/24-9/30/25		Temporary Staff						4029002	75%	247,440.27	-	-	-	
	Agency Management Program			MDW - Staff Augmentation - MDW - 5 Positions - Total															
100071	Agency Management Program	76280	IT	MDW - HealthNet Provider Health Platform - COTS	10/1/24-9/30/25	DigIDee/HealthDC	PDM Host Platform Maintenance and MY Health GPH Maintenance	Competitive	CW94931	Monie Brockett	\$397,242.00		1010001	25%	96,810.50	187,500.00	187,500.00	-	
100071	Agency Management Program	76280	IT	MDW - HealthNet Provider Health Platform - COTS - Total									4029002	75%	290,431.50	562,500.00	562,500.00	-	
	Agency Management Program			MDW - HealthNet Provider Health Platform - COTS - Total															
100071	Agency Management Program	76280	IT	MDW - Medication Therapy Management (MTM)	10/1/24-9/30/25	TBD	TBD	TBD	TBD	TBD	TBD	TBD	1010001	25%	-	-	-	-	Moved to 6000-Operation
100071	Agency Management Program	76280	IT	MDW - Medication Therapy Management (MTM)	10/1/24-9/30/25	TBD	TBD	TBD	TBD	TBD	TBD	TBD	4029002	45%	-	-	-	-	
	Agency Management Program			MDW - Medication Therapy Management (MTM) - Total															
100071	Agency Management Program	76280	IT	CIO Temporary Resources Contract (CW95429 V-Tech) and (CW95427 IUI)	10/1/24-9/30/25	V-Tech & IUI	Temporary Staffing	Bid	CW95429 & CW95427	Erik Thomas	\$4,057,132.29		1010001	25%	143,930.92	-	-	-	Effective January 1, 2025, AVID, V-TECH and IUI resources were transferred under the CAI contract
100071	Agency Management Program	76280	IT	CIO Temporary Resources Contract (CW95429 V-Tech) and (CW95427 IUI)	10/1/24-9/30/25		Temporary Staffing						4029002	75%	441,702.77	-	-	-	
	Agency Management Program			Total-AMF-MDW Program/Cost Center															
	Agency Management Program			MDW - Total AL															
	Agency Management Program	76282	OGC	OAG Legal Review - MOU with OAG	10/1/24-9/30/25	CBO	MOU with OAG	N/A	N/A	N/A	N/A	N/A	4029002	100%	4,657,182.29	5,068,939.64	5,068,939.64	479,110.08	
100092	Agency Management Program	76282	OGC	OAG Legal Review - MOU with OAG - Total															
100092	Agency Management Program	76282	OGC	Reimbursement Appeal - Expert Witness	10/1/24-9/30/25	CBO	MOU with OAG	N/A	N/A	N/A	N/A	N/A	4029002	100%	103,648.72	100,001.00	100,001.00	23,176.40	
	Agency Management Program			Reimbursement Appeal - Expert Witness - Total															
100092	Agency Management Program	76282	OGC	OAG-Reserve Provider Appeal on behalf of DMCF - MOU with OAG - Total	10/1/24-9/30/25	CBO	MOU with OAG	N/A	N/A	N/A	N/A	N/A	4029002	100%	5,014.25	145,001.00	145,001.00	-	
	Agency Management Program			OAG-Reserve Provider Appeal on behalf of DMCF - MOU with OAG - Total															
100092	Agency Management Program	76282	OGC	OAG-Reserve Provider Appeal on behalf of DMCF - MOU with OAG - Total	10/1/24-9/30/25	CBO	MOU with OAG	N/A	N/A	N/A	N/A	N/A	4029002	100%	5,014.25	145,001.00	145,001.00	-	
	Agency Management Program			Total-OGC Program/Cost Center															
	Agency Management Program	76274	OMB	Advertising Contractor - NRC 4 - Total	10/1/24-9/30/25	TBD	Run PSA Ads	Exempt		Muscle Halt			1000132	55%	188,662.97	355,002.00	355,002.00	23,176.40	
100185	Agency Management Program	76274	OMB	Advertising Contractor - NRC 4 - Total	10/1/24-9/30/25	TBD	Run PSA Ads						4029002	45%	-	8,250.00	8,250.00	-	
100185	Agency Management Program	76274	OMB	Commercial Insurance Review - Total	10/1/24-9/30/25	Mercur	Commercial Insurance Review	Legal Review	GSA	CW83065	Muscle Halt	\$119,406.18	1000132	55%	149,200.15	183,890.30	183,890.30	-	
100185	Agency Management Program	76274	OMB	Commercial Insurance Review - Total	10/1/24-9/30/25	Mercur	Commercial Insurance Review						4029002	45%	122,072.02	158,455.70	158,455.70	-	
	Agency Management Program			Health Bill of Rights MOU with DHS															
100185	Agency Management Program	76274	OMB	Health Bill of Rights MOU with DHS	10/1/24-9/30/25	SRO	MOU with Department of Insurance, Securities & Banking (DHSB)						1000132	55%	27,273.00	44,550.00	44,550.00	-	
100185	Agency Management Program	76274	OMB	Health Bill of Rights MOU with DHS	10/1/24-9/30/25	SRO	MOU with Department of Insurance, Securities & Banking (DHSB)						4029002	45%	36,450.00	36,450.00	36,450.00	-	
	Agency Management Program			Health Bill of Rights MOU with DHS - Total															
100185	Agency Management Program	76274	OMB	Independent Review Org (IRO)	10/1/24-9/30/25	ISLAND PIER REVIEW ORG	Subject Matter Expert	Single Quote	PU72080	Muscle Halt	\$5,160.00		1000132	55%	-	2,750.00	2,750.00	-	
100185	Agency Management Program	76274	OMB	Independent Review Org (IRO)	10/1/24-9/30/25	ISLAND PIER REVIEW ORG	Subject Matter Expert						4029002	45%	-	2,750.00	2,750.00	-	
	Agency Management Program			Independent Review Org (IRO) - Total															
100185	Agency Management Program	76274	OMB	Evaluation and Document Management System (EODMS) - Total	10/1/24-9/30/25	UDC	MOU with UDC		N/A	N/A	N/A	N/A	1000132	55%	82,864.50	220,000.00	220,000.00	-	
100185	Agency Management Program	76274	OMB	Evaluation and Document Management System (EODMS) - Total	10/1/24-9/30/25	UDC	MOU with UDC						4029002	45%	67,796.22	180,000.00	180,000.00	-	
	Agency Management Program			Evaluation and Document Management System (EODMS) - Total															
100185	Agency Management Program	76274	OMB	Home Health Temporary Contract - Licensed Social Worker - Total	10/1/24-9/30/25	MediFinders	Assist Clinical Case Workers	DCSS	CW82575	Muscle Halt	\$276,161.60		1000132	55%	170,500.00	170,500.00	170,500.00	-	
100185	Agency Management Program	76274	OMB	Home Health Temporary Contract - Licensed Social Worker - Total	10/1/24-9/30/25	MediFinders	Assist Clinical Case Workers						4029002	45%	-	112,500.00	112,500.00	-	
	Agency Management Program			Home Health Temporary Contract - Licensed Social Worker - Total															
100185	Agency Management Program	76274	OMB	Outreach/Communication Contractor (Public Service Announcement) - Total	10/1/24-9/30/25	TBD	Outreach For OMB	Bid	TBD	Muscle Halt	TBD	TBD	1000132	55%	-	254,000.00	254,000.00	-	
100185	Agency Management Program	76274	OMB	Outreach/Communication Contractor (Public Service Announcement) - Total	10/1/24-9/30/25	TBD	Outreach For OMB						4029002	45%	-	114,944.91	114,944.91	-	
	Agency Management Program			Outreach/Communication Contractor (Public Service Announcement) - Total															
100185	Agency Management Program	76274	OMB	Temporary Staffing - Data Entry Clerks (2)	10/1/24-9/30/25	MediFinders	Temporary Staffing	DCSS	CW112620	Muscle Halt	\$479,987.90		1000132	55%	114,313.16	192,500.00	192,500.00	10,175.62	
100185	Agency Management Program	76274	OMB	Temporary Staffing - Data Entry Clerks (2)	10/1/24-9/30/25	MediFinders	Temporary Staffing						4029002	45%	92,284.65	157,500.00			

Program Code	Program Name	Cost Center	Cost Center Title	Contract Name / Description	Period of Performance	Contract Service Provider	Purpose of Contract	Procurement Method (RfB or Sole Source)	Contract Number	DHCF Employee Responsible for the Contract (CA)	Original Contract Value	Modifications	Funding Source	FY26 Funding Split	FY25 Actuals	FY26 Approved Budget	FY26 Anticipated Cost	FY26 Expenditures thru 12/31/25	COMMENTS	
100101	Agency Management Program	70538	OSDDF	Renewal of DES Licenses to maintain compliance	10/1/24-9/30/25	DSLRO	TBD	TBD	TBD	TBD	TBD	TBD	1010001	5%	-	176.00	176.00	-		
100101	Agency Management Program	70538	OSDDF										4025002	45%	-	144.00	144.00	-		
	Agency Management Program			Renewal of DES Licenses to maintain compliance - Total											-	320.00	320.00	-		
100101	Agency Management Program	70538	OSDDF	SOW HHS USM Contract	10/01/24 - 04/31/25	E7 Strategies	Contractor conduct a comprehensive rate study and develop reimbursement rates for the Home Health services under the	Competitive	CW107016	Angellee Martin	\$172,022.40		1010001	5%	71,184.45	97,526.89	97,526.89	-		
100101	Agency Management Program	70538	OSDDF	SOW HHS USM Contract - Total									4025002	45%	58,204.17	79,794.72	79,794.72	-		
	Agency Management Program			SOW HHS USM Contract - Total											-	172,022.40	177,321.60	-		
100101	Agency Management Program	70538	OSDDF	SOW HHS USM Contract	04/1/25 - 09/30/25	E7 Strategies	Contractor conduct a comprehensive rate study and develop reimbursement rates for the Home Health services under the	Competitive	CW107016	Angellee Martin	\$158,371.20		1010001	5%	69,256.48	89,256.48	89,256.48	-		
100101	Agency Management Program	70538	OSDDF	SOW HHS USM Contract - Total									4025002	45%	56,648.18	71,021.13	71,021.13	-		
	Agency Management Program			SOW HHS USM Contract - Total											-	125,884.00	162,273.60	-		
100101	Agency Management Program	70538	OSDDF	Home Health Rate Study	10/1/24-10/15/24	Buzell	Policies Impact Analysis		CW111777	Angellee Martin	\$143,500.00		1010001	5%	79,525.00	64,248.27	64,248.27	64,248.27		
100101	Agency Management Program	70538	OSDDF	Home Health Rate Study									4025002	45%	64,457.00	52,566.77	52,566.77	-		
	Agency Management Program			Home Health Rate Study - Total											-	143,500.00	116,815.04	116,815.04		
100101	Agency Management Program	70538	OSDDF	Home Health Rate Study	10/16/24 - 09/30/25	Buzell	Policies Impact Analysis		CW111777	Angellee Martin	\$707,704.17		1010001	5%	485,402.49	201,500.00	201,500.00	-		
100101	Agency Management Program	70538	OSDDF	Home Health Rate Study									4025002	45%	292,881.70	396,205.56	396,205.56	-		
	Agency Management Program			Home Health Rate Study - Total											-	698,832.67	881,822.46	881,822.46		
100101	Agency Management Program	70538	OSDDF	NCR Physician Malpractice	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	1010001	5%	201,500.00	201,500.00	201,500.00	-		
100101	Agency Management Program	70538	OSDDF	NCR Physician Malpractice - Total									4025002	45%	166,500.00	166,500.00	166,500.00	-		
	Agency Management Program			Total - OSDDF Programs/Cost Center											-	278,090.00	278,090.00	-		
				OSDDF - TOTAL									1,590,661.83		3,308,386.96	3,308,386.96	3,308,386.96	109,615.04		
100101	Agency Management Program	70275	OD	Legal and Policy Support Review - Support short term initiatives	TBD	CBO	TBD	TBD	TBD	TBD	TBD	TBD	1010001	55%	2,919,725	2,919,725	2,919,725	-		
100101	Agency Management Program	70275	OD	Legal and Policy Support Review - Support short term initiatives									4025002	45%	-	16,917.75	16,917.75	-		
	Agency Management Program			Legal and Policy Support Review - Support short term initiatives - Total											-	37,995.00	37,995.00	-		
100101	Agency Management Program	70275	OD	Technical Advising - Technical Advising & Consulting	TBD		TBD	TBD	TBD	TBD	TBD	TBD	1010001	55%	-	24,200.00	24,200.00	-		
100101	Agency Management Program	70275	OD	Technical Advising - Technical Advising & Consulting									4025002	45%	-	19,800.00	19,800.00	-		
	Agency Management Program			Technical Advising - Technical Advising & Consulting - Total											-	44,000.00	44,000.00	-		
100007	Agency Management Program	70277	OD	Language Line - Office of Human Rights	TBD		TBD	TBD	TBD	TBD	TBD	TBD	1010001	55%	-	19,800.00	19,800.00	-		
100007	Agency Management Program	70277	OD	Language Line - Office of Human Rights									4025002	45%	-	16,200.00	16,200.00	-		
	Agency Management Program			Language Line - Office of Human Rights - Total											-	36,000.00	36,000.00	-		
100108	Agency Management Program	70163	OD	Language Translation Services	10/1/24-4/7/25	Contest Global	Translation Services	Requirements	CW97971	Antonio Lacey	\$108,761.64		1010001	23%	9,808.05	45,302.03	45,302.03	3,891.32		
100108	Agency Management Program	70163	OD	Language Translation Services - Total									4025002	77%	29,424.02	136,506.10	136,506.10	11,671.95		
	Agency Management Program			Language Translation Services - Total											-	162,608.13	162,608.13	15,563.27		
100108	Agency Management Program	70163	OD	Language Translation Services	4/8/25-9/30/25	Contest Global	Translation Services	Requirements	CW97971	Antonio Lacey	\$165,080.77		1010001	23%	9,641.83	45,302.03	45,302.03	-		
100108	Agency Management Program	70163	OD	Language Translation Services									4025002	77%	29,424.02	136,506.10	136,506.10	-		
	Agency Management Program			Language Translation Services - Total											-	162,608.13	162,608.13	-		
				Total - OD Programs/Cost Center											-	77,999.35	481,612.26	481,612.26	15,845.27	
100100	Agency Management Program	70530	OSDDM	Community Outreach Equipment	10/1/24-9/30/25	TBD	TBD	TBD	TBD	TBD	TBD	TBD	1010001	55%	171,725.35	171,725.35	171,725.35	15,502.52		
100100	Agency Management Program	70530	OSDDM	Community Outreach Equipment	10/1/24-9/30/25								4025002	45%	-	197,278.34	197,278.34	-		
	Agency Management Program			Community Outreach Equipment - Total											-	438,996.22	438,996.22	-		
				OSDDM - TOTAL											-	171,725.35	438,996.22	438,996.22	-	
100104	Agency Management Program	70156	PI	EYVE - Electronic Verification of Vital Events	11/01/24-9/30/25	NAPIDS	National Association for Public Health Statistics and Information Systems	Exempt	PV720347	Samantha Dierwile	\$1,500.00		1010001	55%	708.24	825.00	825.00	-		
100104	Agency Management Program	70156	PI	EYVE - Electronic Verification of Vital Events	11/01/24-9/30/25	NAPIDS							4025002	45%	579.47	675.00	675.00	-		
	Agency Management Program			EYVE - Electronic Verification of Vital Events - Total											-	1,287.71	1,500.00	1,500.00	-	
100104	Agency Management Program	70156	PI	Letra News Subscription	11/01/24-9/30/25	Relis	Subscription Renewal	Exempt	RK259447	Carl Dickey	\$19,200.00		1010001	55%	9,680.00	11,935.00	11,935.00	-		
100104	Agency Management Program	70156	PI	Letra News Subscription	11/01/24-9/30/25	Relis							4025002	45%	7,920.00	9,660.00	9,660.00	-		
	Agency Management Program			Letra News Subscription - Total											-	17,600.00	21,595.00	21,595.00	-	
100104	Agency Management Program	70157	PI	Total - PI Program/Cost Center											-	18,087.71	23,200.00	23,200.00	-	
100104	Agency Management Program	70157	PI	PI Management System	10/01/24-3/31/25	Customer Expressions	Tracking System	Sole source	CW98879	Adrian Williams	\$28,750.00		1010001	55%	13,611.45	16,603.13	16,603.13	2,767.19		
100104	Agency Management Program	70157	PI	PI Management System - Total									4025002	45%	12,917.80	13,584.18	13,584.18	2,244.00		
	Agency Management Program			PI Management System - Total											-	30,187.58	30,187.58	-		
100104	Agency Management Program	70157	PI	PI Management System	4/01/25-9/30/25	Customer Expressions	Tracking System	Sole source	CW98879	Adrian Williams	\$57,500.00		1010001	55%	16,603.13	16,603.13	16,603.13	-		
100104	Agency Management Program	70157	PI	PI Management System									4025002	45%	13,584.18	13,584.18	13,584.18	-		
	Agency Management Program			PI Management System - Total											-	30,187.58	30,187.58	-		
100104	Agency Management Program	70157	PI	Alivia PWA Finder	11/01/24-9/30/25	Alivia Analytics	Fraud Waste & Abuse Finder	TBD	TBD	TBD	TBD	TBD	1010001	23%	-	147,905.50	147,905.50	-	New Solicitation for FY26	
100104	Agency Management Program	70157	PI	Alivia PWA Finder	11/01/24-9/30/25	Alivia Analytics							4025002	77%	-	443,986.50	443,986.50	-		
	Agency Management Program			Alivia PWA Finder - Total											-	591,892.00	591,892.00	-		
				Total - PI Program/Cost Center											-	58,907.40	652,557.00	652,557.00	5,801.25	
				PI - TOTAL											-	77,825.51	675,557.00	675,557.00	5,801.25	
100100	Div. of Clinicians, RX & Acute Provider Svcs.	70528	OCMD	PDL - Preferred Drug List	10/1/24-12/31/24	Magellan	Preferred Drug & Supplemental Rebate	Competitive	CW83888	Charlene Fairfax	\$261,271.24		1010001	55%	143,699.18	148,010.22	148,010.22	96,673.88		
100100	Div. of Clinicians, RX & Acute Provider Svcs.	70528	OCMD	PDL - Preferred Drug List	10/1/24-12/31/24								4025002	45%	117,572.06	121,099.27	121,099.27	80,732.84		
				PDL - Preferred Drug List - Total											-	361,271.24	269,109.49	269,109.49	177,406.72	
100100	Div. of Clinicians, RX & Acute Provider Svcs.	70161	OCMD	PDL - Preferred Drug List	1/1/25-9/30/25	Magellan	Preferred Drug & Supplemental Rebate	Competitive	CW88848	Charlene Fairfax	\$80,078.44		1010001	55%	44,018.64	4,011,260.00	4,011,260.00	-		
100100	Div. of Clinicians, RX & Acute Provider Svcs.	70161	OCMD	PDL - Preferred Drug List	1/1/25-9/30/25								4025002	45%	363,797.80	843,750.00	843,750.00	-		
				PDL - Preferred Drug List - Total											-	807,238.44	1,875,000.00	1,875,000.00	-	
100100	Div. of Clinicians, RX & Acute Provider Svcs.	70528	OCMD	QOQ - Quality Improvement QOQ - Quality Improvement																

Program Code	Program Name	Cost Center	Cost Center Title	Contract Name / Description	Period of Performance	Contract Service Provider	Purpose of Contract	Procurement Method (RfB or Sub Source)	Contract Number	DHCP Employee Responsible for the Contract (CA)	Original Contract Value	Modifications	Funding Source	FY26 Funding Split	FY25 Actuals	FY26 Approved Budget	FY25 Anticipated Cost	FY26 Expenditures thru 12/31/25	Comments
150002	Agency Fiscal Officer	10002	Accounting Operations	Revenue Maximization Contract	10/1/24-9/30/25	Sivc Solutions Group, LLC	Revenue Maximization Contract	TBD	TBD	TBD	TBD		409	55%	-	18,909.00	18,909.00	-	
150002	Agency Fiscal Officer	10002	Accounting Operations	Revenue Maximization Contract	10/1/24-9/30/25	Sivc Solutions Group, LLC							4%		-	15,471.00	15,471.00	-	
150002				Revenue Maximization Contract											-	34,380.00	34,380.00	-	
150002	Agency Fiscal Officer	10002	Accounting Operations	RM/TS - Random moment time study contract	10/1/24-9/30/25	Sivc Solutions Group, LLC	RM/TS - Random moment time study contract	Competitive	CYFD-22-C-007	Darin Shaffer	\$117,983.00		409	55%	39,261.20	39,261.20	39,261.20	-	
150002	Agency Fiscal Officer	10002	Accounting Operations	RM/TS - Random moment time study contract	10/1/24-9/30/25	Sivc Solutions Group, LLC							409	49%	32,122.80	32,122.80	32,122.80	-	
150002				RM/TS - Random moment time study contract											71,384.00	71,384.00	71,384.00	-	
150002				RM/TS - Random moment time study contract											2,880,223.81	4,591,122.64	4,591,122.64	-	
100017	Managed Care	70160	IKTDMA	Enrollment Brokerage Services	10/01/24-11/15/24	Maximus	MCO Enrollment	Competitive	CW9430	Araceli Simbulan	\$374,557.81		1010001	55%	206,066.79	175,002.42	175,002.42	173,602.39	
100017	Managed Care	70160	IKTDMA	Enrollment Brokerage Services	10/01/24-11/15/24	Maximus							4025002	45%	108,551.01	175,002.42	175,002.42	173,602.39	
100017	Managed Care	70160	IKTDMA	Enrollment Brokerage Services - Total	11/16/24-09/30/25	Maximus									374,557.80	347,284.83	347,284.83	347,284.77	
100017	Managed Care	70160	IKTDMA	Enrollment Brokerage Services	11/16/24-09/30/25	Maximus	MCO Enrollment	Competitive	CW9430	Araceli Simbulan	\$2,669,371.95		1010001	55%	1,472,030.24	1,520,632.28	1,520,632.28	1,520,632.28	
100017	Managed Care	70160	IKTDMA	Enrollment Brokerage Services - Total											1,305,042.92	1,520,632.28	1,520,632.28	-	
100017	Managed Care	70160	IKTDMA	Enrollment Brokerage Services											2,677,873.36	3,861,264.55	3,861,264.55	-	
100017	Managed Care	70160	IKTDMA	Merced Consulting - Actuarial Services	10/1/24-5/17/25	Merced Consulting	Actuarial Services for MCO Rates	GSA	CW9957	Lisa Truitt	\$2,427,482.73		1010001	55%	1,404,425.55	1,879,917.67	1,879,917.67	-	
100017	Managed Care	70160	IKTDMA	Merced Consulting - Actuarial Services	10/1/24-5/17/25	Merced Consulting							4025002	45%	1,151,059.08	1,570,114.45	1,570,114.45	-	
100017	Managed Care	70160	IKTDMA	Merced Consulting - Actuarial Services - Total	5/18/25-9/30/25	Merced Consulting									2,575,484.63	3,448,032.12	3,448,032.12	-	
100017	Managed Care	70160	IKTDMA	Merced Consulting - Actuarial Services	5/18/25-9/30/25	Merced Consulting	Actuarial Services for MCO Rates	GSA	CW9957	Lisa Truitt	\$3,303,400.00		1010001	55%	1,105,551.62	951,106.50	951,106.50	-	
100017	Managed Care	70160	IKTDMA	Merced Consulting - Actuarial Services	5/18/25-9/30/25	Merced Consulting							4025002	45%	965,907.51	779,809.50	779,809.50	-	
				Merced Consulting - Actuarial Services - Total											2,146,461.13	1,732,916.00	1,732,916.00	-	
100109	Division of Quality & Health Outcomes	70162	IKTDMA	Total - Program Cost Center	10/1/24-8/6/25	QIstar									8,116,766.72	8,839,413.58	8,839,413.58	347,284.77	
100109	Division of Quality & Health Outcomes	70162	IKTDMA	EOBRO - External Quality Review Services	10/1/24-8/6/25	QIstar	External Quality Review Services	Competitive	CW99623	Araceli Simbulan	\$1,090,639.23		1010001	25%	424,623.52	402,915.64	402,915.64	-	
				EOBRO - External Quality Review Services	10/1/24-8/6/25								4025002	73%	1,267,957.66	1,217,746.93	1,217,746.93	-	
				EOBRO - External Quality Review Services - Total											1,690,418.21	1,623,662.57	1,623,662.57	-	
100109	Division of Quality & Health Outcomes	70162	IKTDMA	EOBRO - External Quality Review Services	8/25-9/30/25	QIstar	External Quality Review Services	Competitive	CW99623	Araceli Simbulan	\$319,409.03		1010001	25%	85,506.51	75,393.84	75,393.84	-	
100109	Division of Quality & Health Outcomes	70162	IKTDMA	EOBRO - External Quality Review Services	8/25-9/30/25	QIstar							4025002	73%	256,651.52	226,181.52	226,181.52	-	
				EOBRO - External Quality Review Services - Total											342,262.02	301,575.36	301,575.36	-	
				Total - Program Cost Center											2,632,812.23	1,925,237.93	1,925,237.93	-	
100108	Div. of Children's Health Services	70163	IKTDMA	Court Monitor - Substance Contract	10/1/24-9/30/25	Mathematica	Court Order	N/A	N/A	N/A	N/A		1010001	55%	18,200.35	27,500.00	27,500.00	-	
100108	Div. of Children's Health Services	70163	IKTDMA	Court Monitor - Substance Contract - Total	10/1/24-9/30/25	Mathematica							4025002	45%	15,236.10	22,500.00	22,500.00	-	
100108	Div. of Children's Health Services	70163	IKTDMA	Court Monitor - Substance Contract - Total	10/1/24-9/30/25										33,782.45	50,000.00	50,000.00	-	
100108	Div. of Children's Health Services	70163	IKTDMA	Primary Care Provider Education	10/1/24-9/30/25	Georgetown University	HealthCheck						1010001	55%	78,230.45	74,250.00	74,250.00	-	
100108	Div. of Children's Health Services	70163	IKTDMA	Primary Care Provider Education	10/1/24-9/30/25	Georgetown University	HealthCheck	Exempt	PO718737	Colleen Sosnowsky	\$127,779.00		4025002	45%	57,500.55	60,750.00	60,750.00	-	
				Primary Care Provider Education - Total											127,779.00	135,000.00	135,000.00	-	
				Total - Program Cost Center											164,545.45	185,000.00	185,000.00	-	
				2000 - TOTAL											10,311,116.00	10,649,649.43	10,649,649.43	347,284.77	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - EPD Household Set-up Services/Administrative	10/1/24 - 8/31/25	V-Care							1010001	55%	39,577.08	40,333.33	40,333.33	7,975.00	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - EPD Household Set-up Services/Administrative	10/1/24 - 8/31/25	V-Care							4025002	45%	32,381.25	33,000.00	33,000.00	6,525.00	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Home Health Workforce Development	10/1/24 - 8/31/25	V-Care							4025002	100%	-	51,333.33	51,333.33	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Accessibility Adaptations/Assistive Technology	10/1/24 - 8/31/25	V-Care							1010001	50%	-	20,625.00	20,625.00	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Accessibility Adaptations/Assistive Technology	10/1/24 - 8/31/25	V-Care							4025002	50%	-	20,625.00	20,625.00	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - HCBS Long Term Care Outreach	10/1/24 - 8/31/25	V-Care	Community Transition Services	Competitive	CW10781	Muhs Ndaka	\$58,355.17		4025002	100%	-	4,583.34	4,583.34	-	
100194	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Direct Cost Reimbursement-EPD	10/1/24 - 8/31/25	V-Care							1010001	55%	18,283.28	75,625.00	75,625.00	1,845.25	
100194	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Direct Cost Reimbursement-EPD	10/1/24 - 8/31/25	V-Care							4025002	45%	14,959.08	61,875.00	61,875.00	1,509.75	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Direct Cost Reimbursement-Pre-EPD	10/1/24 - 8/31/25	V-Care							1010001	100%	85,672.82	228,166.67	228,166.67	24,489.99	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Direct Cost Reimbursement- MPP	10/1/24 - 8/31/25	V-Care							4025002	100%	6,079.50	52,563.50	52,563.50	-	
				EPD Community Trn Svcs-Total											196,952.97	589,736.17	589,736.17	41,244.99	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - EPD Household Set-up Services/Administrative	9/1/25-9/30/25	V-Care							1010001	55%	3,616.44	3,666.67	3,666.67	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - EPD Household Set-up Services/Administrative	9/1/25-9/30/25	V-Care							4025002	45%	2,938.90	3,000.00	3,000.00	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Home Health Workforce Development	9/1/25-9/30/25	V-Care							4025002	100%	-	4,666.67	4,666.67	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Accessibility Adaptations/Assistive Technology	9/1/25-9/30/25	V-Care							1010001	50%	-	1,875.00	1,875.00	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Accessibility Adaptations/Assistive Technology	9/1/25-9/30/25	V-Care	Community Transition Services	Competitive	CW10781	Muhs Ndaka	\$53,611.83		4025002	50%	-	1,875.00	1,875.00	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - HCBS Long Term Care Outreach	9/1/25-9/30/25	V-Care							4025002	100%	-	416.66	416.66	-	
100194	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Direct Cost Reimbursement-EPD	9/1/25-9/30/25	V-Care							1010001	55%	1,695.65	6,875.00	6,875.00	-	
100194	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Direct Cost Reimbursement-EPD	9/1/25-9/30/25	V-Care							4025002	45%	1,387.35	5,625.00	5,625.00	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Direct Cost Reimbursement-Pre-EPD	9/1/25-9/30/25	V-Care							1010001	100%	80.00	20,833.33	20,833.33	-	
100193	Long Term Care Support Services	70272	200L	EPD Community Trn Svcs - Direct Cost Reimbursement- MPP	9/1/25-9/30/25	V-Care							4025002	100%	-	4,778.50	4,778.50	-	
				EPD Community Trn Svcs-Total											10,458.34	52,611.83	52,611.83	-	
100194	Long Term Care Support Services	70270	200L	Long Term Care Contract - LTC Assessment Contract	10/1/24-11/6/24	Liberty Health Care Corporation	To provide: (1) intake services; (2) assess applicant programs/med-financial eligibility; (3) determine level of care; (4) recommend a range of service hours; and (5) link home health provider services to beneficiaries.	Source Solicit	CW11090	Benjamin Dheigre	\$861,365.38		1010001	55%	473,640.96	-	-	-	Long Term Assessment Contract with Liberty Health ended 1/31/25
100194	Long Term Care Support Services	70270	200L	Long Term Care Contract - LTC Assessment Contract	10/1/24-11/6/24	Liberty Health Care Corporation							4025002	45%	387,524.42	-	-	-	
				Long Term Care Contract - LTC Assessment Contract - Total											861,165.38	-	-	-	
100194	Long Term Care Support Services	70273	200L	Long Term Care Contract - LTC Assessment Contract	11/7/24-1/31/25	Liberty Health Care Corporation	To provide: (1) intake services; (2) assess applicant programs/med-financial eligibility; (3) determine level of care; (4) recommend a range of service hours; and (5) link home health provider services to beneficiaries.	Source Solicit	CW11090	Benjamin Dheigre	\$1,490,974.42		1010001	55%	682,902.65	1,364,150.37	1,364,150.37	642,622.52	Long Term Assessment Contract with Liberty Health ended 1/31/25
100194	Long Term Care Support Services	70273	200L	Long Term Care Contract - LTC Assessment Contract	11/7/24-1/31/25	Liberty Health Care Corporation							4025002	45%	558,411.26	1,116,123.03	1,116,123.03	525,702.06	
				Long Term Care Contract - LTC Assessment Contract - Total											1,240,913.90	2,480,273.40	2,480,273.40	1,168,404.58	
100194	Long Term Care Support Services	70273	200L	Long Term Care Contract - LTC Assessment Contract	2/1/25 - 9/30/25	Telligen	To provide: (1) intake services; (2) assess applicant programs/med-financial eligibility; (3) determine level of care; (4) recommend a range of service hours; and (5) link home health provider services to beneficiaries.	Competitive	CW114208	Benjamin Dheigre	\$7,480,820.07		1010001	55%	2,584,722.02	2,691,299.44	2,691,299.44	-	
100194	Long Term Care Support Services	70273	200L	Long Term Care Contract - LTC Assessment Contract	2/1/25 - 9/30/25	Telligen							4025002	45%	2,114,322.57	2,281,972.27	2,281,972.27	-	
				Long Term Care Contract - LTC Assessment Contract - Total											4,698,494.99	4,983,271.71	4,983,271.71	-	
100193	Long Term Care Support Services	70272	200L	PDS Consulting Services Contract - PDS Consulting Services Contract	10/1/24 - 10/16/24	Guardant	Participant Directed Services	Competitive	CW10501	Benjamin Dheigre	\$187,965.32		1010001	55%	92,380.03	171,262.94	102,891.02	102,891.02	
100193	Long Term Care Support Services	70272	200L	PDS Consulting Services Contract - PDS Consulting Services Contract	10/1/24 - 10/16/24	Guardant							4025002	45%	75,584.39	140,307.86	84,183.56	84,183.56	
				PDS Consulting Services Contract - PDS Consulting Services Contract - Total															

Program Code	Program Name	Cost Center	Cost Center Title	Contract Name / Description	Period of Performance	Contract Service Provider	Purpose of Contract	Procurement Method (Bid or Sole Source)	Contract Number	DHCP Employee Responsible for the Contract (CA)	Original Contract Value	Modifications	Funding Source	FY26 Funding Split	FY25 Actuals	FY26 Approved Budget	FY26 Anticipated Cost	FY26 Expenditures thru 12/31/25	COMMENTS	
100193	Long Term Care Support Services	70272	200L	Money Follow The Person (MFP) Grant	10/1/24-9/30/25	TBD	TBD	TBD	TBD	TBD	TBD	TBD	4020002	100%	6,079.50	1,705,692.00	1,705,692.00	-		
Money Follow The Person (MFP) Grant - Total																				
100194	Long Term Care Support Services	70273	200L	LTC- ARPA Staffing	10/1/24-9/30/25	Advantageous	Assisted Living Study Contract	Talk Order	CW10349	Benjamin Dheighe	\$80,980.00	10/0001	55%	252,376.22	140,550.67	140,550.67	1,312.65		Contract ended	
100193	Long Term Care Support Services	70271	200L	LTC- ARPA Staffing	10/1/24-9/30/25	Advantageous						4020002	45%	211,035.09	114,996.00	114,996.00	2,563.00			
100193	Long Term Care Support Services	70272	200L	LTC- ARPA Staffing - Total	10/1/24-12/02/25							10/0001	5%	\$13,411.31	\$25,546.67	\$25,546.67	\$,609.73			
100193	Long Term Care Support Services	70272	200L	DACL Dualt. SHIP staff	10/1/24-12/02/25	Midwom	Temporary Support	Talk Order	CW11332	Benjamin Dheighe	\$14,615.76	4020002	45%	6,577.09	11,250.00	11,250.00	5,280.00			
100193	Long Term Care Support Services	70272	200L	DACL Dualt. SHIP staff - Total	1/21/25-9/30/25	Midwom	Temporary Support	Talk Order	CW11332	Benjamin Dheighe	\$67,817.01	10/0001	55%	14,615.76	25,000.00	25,000.00	11,733.93			
100193	Long Term Care Support Services	70272	200L	DACL Dualt. SHIP staff	1/21/25-9/30/25	Midwom	Temporary Support					4020002	45%	10,517.65	33,750.00	33,750.00	-			
DACL Dualt. SHIP staff - Total																				
100194	Long Term Care Support Services	70273	200L	Quality Management Strategy contract	10/1/24-11/25	IBMA	Quality Mgmt Services	Competitive	CW116089	Benjamin Dheighe	\$760,551.00	10/0001	55%	267,698.38	128,381.00	128,381.00	-		Contract was not executed	
100194	Long Term Care Support Services	70273	200L	Quality Management Strategy contract	10/1/24-11/25	IBMA						4020002	45%	219,025.94	105,039.00	105,039.00	-			
Quality Management Strategy contract - Total																				
100194	Long Term Care Support Services	70273	200L	Quality Management Strategy contract	04/25-9/30/25	IBMA	Quality Mgmt Services	Competitive	CW116089	Benjamin Dheighe	\$760,551.00	10/0001	55%	-	132,245.00	132,245.00	-			
100194	Long Term Care Support Services	70273	200L	Quality Management Strategy contract	04/25-9/30/25	IBMA						4020002	45%	-	107,365.50	107,365.50	-			
Quality Management Strategy contract - Total																				
100203	Long Term Care Support Services	70261	200L	DC Care Contract - Client Case Management System - CCM-OM	10/1/24 - 4/6/25	FELCOM INC	Operations & Maintenance	Sole Source	CW98668	Araceli Simbula	\$615,920.40	10/0001	25%	153,980.30	182,542.50	182,542.50	52,155.00			
700203	Long Term Care Support Services	70261	200L	DC Care Contract - Client Case Management System - CCM-OM	10/1/24 - 4/6/25	FELCOM INC						4020002	75%	461,940.30	547,627.50	547,627.50	156,465.00			
DC Care Contract - Client Case Management System - CCM-OM - Total																				
100203	Long Term Care Support Services	70261	200L	DC Care Contract - Client Case Management System - CCM-OM	4/7/25 - 9/30/25	FELCOM INC	Operations & Maintenance	Sole Source	CW98668	Araceli Simbula	\$99,953.00	10/0001	25%	151,249.50	147,286.67	147,286.67	-			
700203	Long Term Care Support Services	70261	200L	DC Care Contract - Client Case Management System - CCM-OM	4/7/25 - 9/30/25	FELCOM INC						4020002	75%	453,748.50	441,860.02	441,860.02	-			
DC Care Contract - Client Case Management System - CCM-OM - Total																				
Total - Procurement Center															13,532,799.34	18,972,142.47	18,972,142.47	1,810,947.99		
Total - TOTAL															13,532,799.34	18,972,142.47	18,972,142.47	1,810,947.99		
100197	Health Care Policy	70266	3000	HCPRM-Medicaid Eligibility Enhancement Initiative	10/1/24-2/14/25	UMASS	Medical Eligibility Enhancement Initiative	Sole source	CW123493	Carlin Brandt		10/0001	55%	-	492,460.65	492,460.65	-		The period of performance was scheduled to begin on February 15, 2025; however, due to ongoing contract negotiations, no expenditures were incurred during the fiscal year. The negotiations concluded in late August, which prevented any work from commencing	
100197	Health Care Policy	70266	3000	HCPRM-Medicaid Eligibility Enhancement Initiative	10/1/24-2/14/25	UMASS						4020002	45%	-	892,022.35	892,022.35	-			
HCPRM-Medicaid Eligibility Enhancement Initiative - Total																				
100197	Health Care Policy	70266	3000	HCPRM-Medicaid Eligibility Enhancement Initiative	2/15/25-9/30/25	UMASS	Medical Eligibility Enhancement Initiative	Sole source	OW123493	Catrin Brandt	\$ 334,434.33	10/0001	55%	-	150,351.30	150,351.30	-			
100197	Health Care Policy	70266	3000	HCPRM-Medicaid Eligibility Enhancement Initiative	2/15/25-9/30/25	UMASS						4020002	45%	-	123,014.70	123,014.70	-			
HCPRM-Medicaid Eligibility Enhancement Initiative - Total																				
Total - Procurement Center															-	1,618,749.00	1,618,749.00	-		
100196	Health Care Policy	70263	3000	HCPRM Temporary Staffing	10/1/24-9/30/25	Midwom	Temporary Support	Bid	CW8817	William Woods	\$70,474.24	10/0001	55%	-	82,500.00	82,500.00	-		Contract has ended- New Solicitation	
100196	Health Care Policy	70263	3000	HCPRM Temporary Staffing	10/1/24-9/30/25	Midwom						4020002	45%	-	47,500.00	47,500.00	-			
HCPRM Temporary Staffing - Total																				
100196	Health Care Policy	70263	3000	HCPRM Temporary Staffing	10/1/24-9/30/25	Midwom	Temporary Support	Bid	CW8817	William Woods	\$90,943.93	10/0001	55%	-	150,000.00	150,000.00	-			
100196	Health Care Policy	70263	3000	HCPRM Temporary Staffing	10/1/24-9/30/25	Midwom						4020002	45%	-	93,200.00	93,200.00	-			
HCPRM Temporary Staffing - Total																				
100196	Health Care Policy	70263	3000	Current Annual Subscriptions and Professional Services Contract	10/1/24-9/30/25	West Publishing Corp (WestLaw)	Subscription	Small Purchase	PJ71823	Ektorina Christopherson	\$28,991.04	10/0001	55%	15,945.07	35,805.00	35,805.00	1,395.19			
100196	Health Care Policy	70263	3000	Current Annual Subscriptions and Professional Services Contract	10/1/24-9/30/25	West Publishing Corp (WestLaw)						4020002	45%	13,045.97	29,295.00	29,295.00	1,141.52			
Current Annual Subscriptions and Professional Services Contract - Total																				
100197	Health Care Policy	70266	3000	Alliance Backup Applications Temporary Resources	10/01/24-04/10/25	Roos Professional Services LLC	Temporary Staff	RFTOP	CW10705	Taylor Woods	\$771,355.36	10/0001	55%	-	286,130.42	-	-		Contract ended 4/10/25	
100197	Health Care Policy	70266	3000	Alliance Backup Applications Temporary Resources	10/01/24-04/10/25	Roos Professional Services LLC						4020002	45%	-	168,652.16	-	-			
Alliance Backup Applications Temporary Resources - Total																				
Total - Procurement Center															274,782.58	274,782.58	274,782.58	2,536.70		
100198	DCAS	70152	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)	Temporary Staff	Bid	CW95481, CW93471, CW44171, CW101930	Kashonda Johnson-Dunkin	\$23,154,227.62	4020002	39.75%	572,391.79	1,683,849.00	1,683,849.00	2,536.70			
100198	DCAS	70152	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	13.25%	166,441.15	176,778.32	176,778.32	47,995.95			
100198	DCAS	70152	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	15.00%	166,444.44	200,126.40	200,126.40	54,535.04			
100198	DCAS	70152	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	17.00%	152,283.12	226,809.82	226,809.82	61,579.71			
DCAS - R1/R2/R3 Staff Aaaa																				
100199	DCAS	70153	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)	Temporary Staff	Bid	CW95481, CW93471, CW44171, CW101930	Kashonda Johnson-Dunkin		4020002	39.75%	1,119,118.46	1,319,210.65	1,319,210.65	366,994.97			
100199	DCAS	70153	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	13.25%	373,639.89	446,401.55	446,401.55	122,314.66			
100199	DCAS	70153	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						4020002	15.00%	341,425.97	505,362.51	505,362.51	138,468.67			
100199	DCAS	70153	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	17.00%	341,425.97	505,362.51	505,362.51	138,468.67			
DCAS- R1/R2/R3 Staff Aaaa																				
100201	DCAS	70154	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)	Temporary Staff	Bid	CW95481, CW93471, CW44171, CW101930	Kashonda Johnson-Dunkin		4020002	39.75%	2,829,081.26	3,360,082.40	3,360,082.40	923,257.78			
100201	DCAS	70154	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	13.25%	34,138.27	169,356.82	169,356.82	52,807.39			
100201	DCAS	70154	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						4020002	15.00%	31,245.19	191,724.71	191,724.71	59,782.18			
100201	DCAS	70154	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	17.00%	31,245.19	191,724.71	191,724.71	59,782.18			
DCAS- R1/R2/R3 Staff Aaaa																				
100202	DCAS	70155	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)	Temporary Staff	Bid	CW95481, CW93471, CW44171, CW101930	Kashonda Johnson-Dunkin		4020002	39.75%	129,631.67	1,678,164.70	1,678,164.70	298,547.68			
100202	DCAS	70155	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	13.25%	26,768.57	78,097.59	78,097.59	42,567.31			
100202	DCAS	70155	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						4020002	15.00%	26,164.00	88,906.20	88,906.20	42,906.39			
100202	DCAS	70155	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	15.00%	24,161.03	88,805.20	88,805.20	42,906.39			
100202	DCAS	70155	300A	DCAS- R1/R2/R3 Staff Aaaa	10/01/24 - 9/30/25	AVID SYSTEMS (FY25), CAI (FY25-26), DRONAFY25-26, ENLIGHTENED (FY25)						10/0001	17.00%	25,236.00	99,813.39	99,813.39	54,729.90			
DCAS - R1/R2/R3 Staff Aaaa																				
Total - Procurement Center															1,698,408.42	5,872,438.66	5,872,438.66	1,213,975.91		
100203	DCAS	70155	300A	Document/Web/ETC. Translation Services	10/01/24 - 9/30/25	Andean Consulting Solutions	ACST Translation Services	Requirements	CW108302	Kashonda Johnson-Dunkin	\$250,000.00	4020002	39.75%	1,4512.18	68,568.75	68,568.75	4,939.99			
100203	DCAS	70155	300A	Document/Web/ETC. Translation Services	10/01/24 - 9/30/25	Andean Consulting Solutions						10/0001	44.875	22,896.29	22,896.29	22,896.29	1,648.66			
100203	DCAS	70155	300A	Document/Web/ETC. Translation Services	10/01/24 - 9/30/25	Andean Consulting Solutions						4020002	44.875	4,247.45	25,675.00	25,675.00	42,906.39			
100203	DCAS	70155	300A	Document/Web/ETC. Translation Services	10/01/24 - 9/30/25	Andean Consulting Solutions						10/0001	15.00%	4,247.45	25,675.00	25,675.00	1,864.15			
100203	DCAS	70155	300A	Document/Web/ETC. Translation Services	10/01/24 - 9/30/25	Andean Consulting Solutions						10/0001	15.00%	4,991.42	29,125.00	29,125.00	2,112.30			
DCAS - Document/Web/ETC. Translation Services																				
100203	DCAS	70155	300A	DCAS- O&M Vendor	10/01/24 - 9/30/25	D2sol	Operation & Maintenance	Competitive	Cw12148	Kashonda Johnson-Dunkin	\$12,216,892.42	4020002	39.75%	32,798.89	172,866.00	172,866.00	12,427.48			
100203	DCAS	70155	300A	DCAS- O&M Vendor	10/01/24 - 9/30/25	D2sol						10/0001	13.25%	4,375,261.81	4,350,571.74	4,350,571.74	42,567.31			
100203	DCAS	70155	300A	DCAS- O&M Vendor	10/01/24 - 9/30/25	D2sol						4020002	15.00%	4,005,392.16	4,925,114.42	4,925,114.42	42,906.39			
100203	DCAS	70155	300A	DCAS- O&M Vendor	10/01/24 - 9/30/25	D2sol						10/0001	15.00%	4,005,392.16	4,925,114.42	4,925,114.42	42,906.39			
DCAS - O&M Vendor																				
100203	DCAS	70155	300A	Third Party Security Assessment	10/01/24 - 9/30/25	BDA Global	COO Risk Assessment/BDA Global	Competitive	CW09061	Monica Brockett	\$474,799.00	4020002	39.75%	25,669,973.99	22,834,406.15	22,83				

Program Code	Program Name	Cost Center	Cost Center Title	Contract Name / Description	Period of Performance	Contract Service Provider	Purpose of Contract	Procurement Method (Bid or Source Source)	Contract Number	BIHC Employee Responsible for the Contract (CA)	Original Contract Value	Modification	Funding Source	FY26 Funding Ytd	FY25 Actual	FY26 Approved Budget	FY26 Anticipated Cost	FY26 Expenditures thru 12/31/25	COMMENTS
100201	DCAS	70154	300A	Tier 1 Call Center Contract	12/06/24 - 9/30/25	Maximus	Call Center	Competitive	CW95848	Kashonda Johnson-Dunkin	\$7,473,148.32		4029002	39.75%	2,962,306.53	3,654,160.66	3,654,160.66	458,119.36	
100201	DCAS	70154	300A	Tier 1 Call Center Contract	12/06/24 - 9/30/25	Maximus							1010001	13.25%	1,200,768.44	1,218,053.55	1,218,053.55	152,706.45	
100071	DCAS	70221	300A	Tier 1 Call Center Contract	12/06/24 - 9/30/25	Maximus							4029002	15.00%	842,737.59	1,379,828.55	1,379,828.55	172,875.23	
100201	DCAS	70154	300A	Tier 1 Call Center Contract	12/06/24 - 9/30/25	Maximus							1010001	13.00%	842,737.59	1,379,828.55	1,379,828.55	172,875.23	
100201	DCAS	70154	300A	Tier 1 Call Center Contract	12/06/24 - 9/30/25	Maximus							4029002	15.00%	873,090.00	1,562,785.69	1,562,785.69	195,925.26	
	DCAS	70154	300A												6,142,610.64	9,192,807.81	9,192,807.81	1,182,561.13	
100201	DCAS	70154	300A	DCAS- Joint Notices (BIHC MOU)	10/01/24 - 09/30/25	HBX							4029002	39.75%	43,123.41	36,369.92	36,369.92	-	
100201	DCAS	70154	300A	DCAS- Joint Notices (BIHC MOU)	10/01/24 - 09/30/25	HBX							1010001	13.25%	14,441.14	12,123.31	12,123.31	-	
100071	DCAS	70221	300A	DCAS- Joint Notices (BIHC MOU)	10/01/24 - 09/30/25	HBX							4029002	15.00%	13,217.31	13,724.50	13,724.50	-	
100201	DCAS	70154	300A	DCAS- Joint Notices (BIHC MOU)	10/01/24 - 09/30/25	HBX							1010001	13.00%	13,217.31	13,724.50	13,724.50	-	
100201	DCAS	70154	300A	DCAS- Joint Notices (BIHC MOU)	10/01/24 - 09/30/25	HBX							1010001	17.00%	13,786.84	15,554.43	15,554.43	-	
	DCAS	70154	300A												97,700.00	91,476.64	91,476.64	-	
100202	DCAS	70155	300A	DCAS- Marketing	10/01/24 - 09/30/25	DIECF							4029002	39.75%	115,935.00	-	-	-	
100199	DCAS	70153	300A	DCAS- Marketing	10/01/24 - 09/30/25	DIECF							1010001	13.25%	36,445.00	-	-	-	
100071	DCAS	70221	300A	DCAS- Marketing	10/01/24 - 09/30/25	DIECF							4029002	15.00%	35,370.00	-	-	-	
100202	DCAS	70155	300A	DCAS- Marketing	10/01/24 - 09/30/25	DIECF							1010001	15.00%	35,370.00	-	-	-	
100202	DCAS	70155	300A	DCAS- Marketing	10/01/24 - 09/30/25	DIECF							1010001	17.00%	36,080.00	-	-	-	
	DCAS	70155	300A												262,000.00	-	-	-	
100202	DCAS	70155	300A	DCAS- OCTO MOU	10/01/24 - 09/30/25	OCTO							4029002	39.75%	1,907,188.82	387,680.35	387,680.35	-	
100202	DCAS	70155	300A	DCAS- OCTO MOU	10/01/24 - 09/30/25	OCTO							1010001	13.25%	302,393.54	129,226.78	129,226.78	-	
100071	DCAS	70221	300A	DCAS- OCTO MOU	10/01/24 - 09/30/25	OCTO							4029002	15.00%	459,818.18	146,294.47	146,294.47	-	
100202	DCAS	70155	300A	DCAS- OCTO MOU	10/01/24 - 09/30/25	OCTO							1010001	15.00%	459,818.18	146,294.47	146,294.47	-	
100202	DCAS	70155	300A	DCAS- OCTO MOU	10/01/24 - 09/30/25	OCTO							1010001	17.00%	476,148.49	163,800.40	163,800.40	-	
	DCAS	70155	300A												3,186,000.02	975,296.49	975,296.49	-	
100199	DCAS	70153	300A	DCAS- Receptionists	10/01/24 - 09/30/25	AVID SYSTEMS	Temporary Staff	Competitive	CW95425	William Northen	\$51,584.00		4029002	26.50%	14,872.13	14,832.21	14,869.76	-	
100199	DCAS	70153	300A	DCAS- Receptionists	10/01/24 - 09/30/25	AVID SYSTEMS							1010001	24.50%	14,872.13	14,832.21	14,869.76	-	
100071	DCAS	70221	300A	DCAS- Receptionists	10/01/24 - 09/30/25	AVID SYSTEMS							4029002	15.00%	6,805.89	8,395.59	7,737.60	-	
100199	DCAS	70153	300A	DCAS- Receptionists	10/01/24 - 09/30/25	AVID SYSTEMS							1010001	13.00%	6,805.89	8,395.59	7,737.60	-	
100199	DCAS	70153	300A	DCAS- Receptionists	10/01/24 - 09/30/25	AVID SYSTEMS							1010001	17.00%	9,937.00	8,269.28	8,269.28	-	
	DCAS	70153	300A												50,414.00	55,978.39	51,584.00	-	
100202	DCAS	70155	300A	Cloud Subscription-Maintenance	10/01/24 - 09/30/25	MIRATIVE							4029002	39.75%	352,571.08	878,711.67	878,711.67	-	
100202	DCAS	70155	300A	Cloud Subscription-Maintenance	10/01/24 - 09/30/25	MIRATIVE							1010001	13.25%	184,223.96	290,237.69	290,237.69	-	
100071	DCAS	70221	300A	Cloud Subscription-Maintenance	10/01/24 - 09/30/25	MIRATIVE							4029002	15.00%	168,611.76	328,570.97	328,570.97	-	
100202	DCAS	70155	300A	Cloud Subscription-Maintenance	10/01/24 - 09/30/25	MIRATIVE							1010001	13.00%	168,611.76	328,570.97	328,570.97	-	
100202	DCAS	70155	300A	Cloud Subscription-Maintenance	10/01/24 - 09/30/25	MIRATIVE							1010001	17.00%	174,836.64	372,300.43	372,300.43	-	
	DCAS	70155	300A												1,240,756.00	2,198,473.13	2,198,473.13	-	
100202	DCAS	70155	300A	DCAS- Services	10/01/24 - 09/30/25	DIECF							4029002	39.75%	11,062.50	-	-	-	
100202	DCAS	70155	300A	DCAS- Services	10/01/24 - 09/30/25	DIECF							1010001	13.25%	3,167.50	-	-	-	
100071	DCAS	70221	300A	DCAS- Services	10/01/24 - 09/30/25	DIECF							4029002	15.00%	3,375.00	-	-	-	
100202	DCAS	70155	300A	DCAS- Services	10/01/24 - 09/30/25	DIECF							1010001	15.00%	3,375.00	-	-	-	
100202	DCAS	70155	300A	DCAS- Services	10/01/24 - 09/30/25	DIECF							1010001	17.00%	3,580.00	-	-	-	
	DCAS	70155	300A												25,000.00	-	-	-	
100201	DCAS	70154	300A	RUI2 App Dev Support	10/01/24 - 09/30/25	CDE							4029002	39.75%	655,203.40	-	-	-	
100201	DCAS	70154	300A	RUI2 App Dev Support	10/01/24 - 09/30/25	CDE							1010001	13.25%	218,401.20	-	-	-	
100071	DCAS	70221	300A	RUI2 App Dev Support	10/01/24 - 09/30/25	CDE							4029002	15.00%	206,906.40	-	-	-	
100201	DCAS	70154	300A	RUI2 App Dev Support	10/01/24 - 09/30/25	CDE							1010001	15.00%	206,906.40	-	-	-	
100201	DCAS	70154	300A	RUI2 App Dev Support	10/01/24 - 09/30/25	CDE							1010001	17.00%	245,222.40	-	-	-	
	DCAS	70154	300A												1,522,440.00	-	-	-	
100202	DCAS	70155	300A	DCAS- Domain Registration	10/01/24 - 09/30/25	CARASOFT							4029002	39.75%	8,437.50	-	-	-	
100202	DCAS	70155	300A	DCAS- Domain Registration	10/01/24 - 09/30/25	CARASOFT							1010001	13.25%	2,212.50	-	-	-	
100071	DCAS	70221	300A	DCAS- Domain Registration	10/01/24 - 09/30/25	CARASOFT							4029002	15.00%	2,025.00	-	-	-	
100202	DCAS	70155	300A	DCAS- Domain Registration	10/01/24 - 09/30/25	CARASOFT							1010001	15.00%	2,025.00	-	-	-	
100202	DCAS	70155	300A	DCAS- Domain Registration	10/01/24 - 09/30/25	CARASOFT							1010001	17.00%	2,100.00	-	-	-	
	DCAS	70155	300A												15,000.00	-	-	-	
100201	DCAS	70154	300A	Google Translate API	10/01/24 - 09/30/25	CARASOFT							4029002	39.75%	132,700.00	180,386.77	180,386.77	-	
100201	DCAS	70154	300A	Google Translate API	10/01/24 - 09/30/25	CARASOFT							1010001	13.25%	44,230.82	60,128.92	60,128.92	-	
100071	DCAS	70221	300A	Google Translate API	10/01/24 - 09/30/25	CARASOFT							4029002	15.00%	40,500.00	60,070.48	60,070.48	-	
100201	DCAS	70154	300A	Google Translate API	10/01/24 - 09/30/25	CARASOFT							1010001	15.00%	40,500.00	60,070.48	60,070.48	-	
100201	DCAS	70154	300A	Google Translate API	10/01/24 - 09/30/25	CARASOFT							1010001	17.00%	77,146.54	77,146.54	77,146.54	-	
	DCAS	70154	300A												380,000.00	453,803.20	453,803.20	-	
100201	DCAS	70154	300A	DCAS- DBS MOU	10/01/24 - 09/30/25	DBS							1010001	100.00%	88,999.99	88,000.00	88,000.00	-	
	DCAS	70154	300A												88,999.99	88,000.00	88,000.00	-	
100202	DCAS	70155	300A	DCAS- DMV Interface for D3	10/01/24 - 09/30/25	DMV							4029002	39.75%	3,097.50	-	-	-	
100202	DCAS	70155	300A	DCAS- DMV Interface for D3	10/01/24 - 09/30/25	DMV							1010001	13.25%	1,037.50	-	-	-	
100071	DCAS	70221	300A	DCAS- DMV Interface for D3	10/01/24 - 09/30/25	DMV							4029002	15.00%	945.00	-	-	-	
100202	DCAS	70155	300A	DCAS- DMV Interface for D3	10/01/24 - 09/30/25	DMV							1010001	15.00%	945.00	-	-	-	
100202	DCAS	70155	300A	DCAS- DMV Interface for D3	10/01/24 - 09/30/25	DMV							1010001	17.00%	980.00	-	-	-	
	DCAS	70155	300A												7,000.00	-	-	-	
100202	DCAS	70155	300A	DCAS- NAPRIS Interface for D3	10/01/24 - 09/30/25	NAPRIS							4029002	39.75%	79,495.13	-	-	-	
100202	DCAS	70155	300A	DCAS- NAPRIS Interface for D3	10/01/24 - 09/30/25	NAPRIS							1010001	13.25%	13,164.38	-	-	-	
100071	DCAS	70221	300A	DCAS- NAPRIS Interface for D3	10/01/24 - 09/30/25	NAPRIS							4029002	15.00%	12,048.75	-	-	-	
100202	DCAS	70155	300A																

Program Code	Program Name	Cost Center	Cost Center Title	Contract Name / Description	Period of Performance	Contract Service Provider	Purpose of Contract	Procurement Method (Bid or Sole Source)	Contract Number	DHCF Employee Responsible for the Contract (CA)	Original Contract Value	Modification	Funding Source	FY26 Funding Ytd	FY25 Actual	FY26 Approved Budget	FY26 Anticipated Cost	FY26 Expenditures thru 12/31/25	Comments
100203	Health Care Operations Administration	70261	6000	MTA-MMIS Upgrade	10/12-4/30/25	Ernst & Young, LLP/Cambria Solutions	TBD	TBD	TBD	TBD	TBD	TBD	10/0001	10%	-	65,000.00	65,000.00	-	APD RELATED
100203	Health Care Operations Administration	70261	6000	MTA-MMIS Upgrade - Total									402502	90%	-	585,000.00	585,000.00	-	
100203	Health Care Operations Administration	70261	6000	Pharmacy Point of Sale	10/12-4/3/19/25	Prime Therapeutics	Pharmacy Point of Sale	Sole Source	CW97804	Erkine Calderon	\$5,954,613.04		10/0001	23%	1,205,380.12	1,434,409.21	1,434,409.21	270,034.26	APD RELATED - Contract includes Medication Therapy Management (MTM)
100203	Health Care Operations Administration	70261	6000	Pharmacy Point of Sale - Total									402502	75%	322,901.46	4,302,827.64	4,302,827.64	812,562.78	
100203	Health Care Operations Administration	70261	6000	Pharmacy Point of Sale	7/20/25-9/30/25	Prime Therapeutics	Pharmacy Point of Sale	Sole Source	CW97804	Erkine Calderon	\$1,285,364.40		10/0001	25%	33,538.82	5,738,434.85	5,738,434.85	1,083,417.04	APD RELATED - Contract includes Medication Therapy Management (MTM)
100203	Health Care Operations Administration	70261	6000	Pharmacy Point of Sale - Total									402502	90%	968,944.39	1,072,403.97	1,072,403.97	-	
100203	Health Care Operations Administration	70261	6000	Preview Database System	10/12-4/17/25	CAQH	Preview Database System	Exempt	CW110195	Don Shearer	\$65,500.00		10/0001	55%	1,291,923.86	1,429,871.96	1,429,871.96	-	
100203	Health Care Operations Administration	70261	6000	Preview Database System - Total									402502	45%	40,771.59	3,719.00	3,719.00	-	
100203	Health Care Operations Administration	70261	6000	Provider Data Mgmt System - PDMS	10/12-4/16/25	Maximus	Provider Data Mgmt System - PDMS	Sole Source	CW106469	Don Shearer	\$3,643,308.00		10/0001	23%	227,706.73	318,709.30	318,709.30	146,068.59	APD RELATED
100203	Health Care Operations Administration	70261	6000	Provider Data Mgmt System - PDMS - Total									402502	75%	681,120.25	956,357.89	956,357.89	438,205.76	
100203	Health Care Operations Administration	70261	6000	Provider Data Mgmt System - PDMS	1/7-25-9/30/25	Maximus	Provider Data Mgmt System	Sole Source	CW118051	Don Shearer	\$3,759,300.00		10/0001	25%	667,308.63	717,276.26	717,276.26	584,274.24	APD RELATED
100203	Health Care Operations Administration	70261	6000	Provider Data Mgmt System - PDMS - Total									402502	75%	1,971,925.88	2,151,828.79	2,151,828.79	-	
100203	Health Care Operations Administration	70261	6000	Independent Verification and Validation (IV&V)	10/12-4/31/25	TBD	TBD	TBD	TBD	TBD	TBD	TBD	10/0001	100%	-	240,000.00	240,000.00	-	APD Related - Contract started in April, 2025
100203	Health Care Operations Administration	70261	6000	Independent Verification and Validation (IV&V) - Total									402502	90%	-	2,160,000.00	2,160,000.00	-	
100203	Health Care Operations Administration	70261	6000	Independent Verification and Validation (IV&V)	4/1-25-9/30/25	PCG Consulting	Independent IV&V for MMIS	Competitive	CW120781	Don Shearer			10/0001	10%	55,000.00	240,000.00	240,000.00	-	APD Related
100203	Health Care Operations Administration	70261	6000	Independent Verification and Validation (IV&V) - Total									402502	90%	495,000.00	2,160,000.00	2,160,000.00	-	
100203	Health Care Operations Administration	70261	6000	Senior Consultant (CCMS) - Maria Suarez	10/12-4/9/30/25	Aval Systems	Consulting Services	Competitive	CW94253	Cheryl Dodd	\$277,760.00		10/0001	55%	148,302.00	173,250.00	173,250.00	22,176.00	
100203	Health Care Operations Administration	70261	6000	Senior Consultant (CCMS) - Maria Suarez - Total									402502	45%	121,338.00	141,750.00	141,750.00	18,144.00	
100203	Health Care Operations Administration	70261	6000	Senior Consultant (TPU) - Fran Coury	10/12-4/9/30/25	Aval Systems	Consulting Services	Competitive	CW94253	Cheryl Dodd	\$277,760.00		10/0001	55%	152,440.00	173,250.00	173,250.00	22,176.00	
100203	Health Care Operations Administration	70261	6000	Senior Consultant (TPU) - Fran Coury - Total									402502	45%	124,780.00	141,750.00	141,750.00	18,144.00	
100203	Health Care Operations Administration	70261	6000	Senior Consultant (PRM) - Patty Lynn	10/12-4/9/30/25	Aval Systems	Consulting Services	Competitive	CW94253	Cheryl Dodd	\$277,760.00		10/0001	55%	148,456.00	173,250.00	173,250.00	22,176.00	
100203	Health Care Operations Administration	70261	6000	Senior Consultant (PRM) - Patty Lynn - Total									402502	45%	121,664.00	141,750.00	141,750.00	18,144.00	
100203	Health Care Operations Administration	70261	6000	Senior Consultant (PDMS) - Keanan Byrum	10/12-4/9/30/25	Aval Systems	Consulting Services	Competitive	CW94253	Cheryl Dodd	\$277,760.00		10/0001	55%	148,456.00	173,250.00	173,250.00	22,176.00	
100203	Health Care Operations Administration	70261	6000	Senior Consultant (PDMS) - Keanan Byrum - Total									402502	45%	141,750.00	141,750.00	141,750.00	-	
100203	Health Care Operations Administration	70261	6000	Subject Matter Expert (MMIS) - Sam Walker	10/12-4/9/30/25	Aval Systems	Consulting Services	Competitive	CW94253	Cheryl Dodd	\$333,312.00		10/0001	55%	177,222.20	199,100.00	199,100.00	26,611.20	
100203	Health Care Operations Administration	70261	6000	Subject Matter Expert (MMIS) - Sam Walker - Total									402502	45%	145,000.00	162,900.00	162,900.00	21,772.80	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Recovery	10/12-4/12/25	HBS	TPU Recoveries	Competitive	CW81471	Don Shearer	\$2,685,000.00		1000128	55%	27,910.94	683,063.04	683,063.04	32,412.19	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Recovery - Total									402502	45%	104,654.41	558,369.76	558,369.76	39,614.89	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Recovery	1/24-25-9/30/25	HBS	TPU Recoveries	Competitive	CW81471	Don Shearer	\$2,685,000.00		1000128	55%	161,397.11	828,993.40	828,993.40	72,027.01	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Recovery - Total									402502	45%	132,052.19	1,011,214.40	1,011,214.40	-	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Verification	10/12-4/5/31/25	Zane Networks	TPU Verification	Competitive	CW81817	Cheryl Dodd	\$1,620,000.00		1000128	55%	293,449.29	1,842,238.00	1,842,238.00	-	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Verification - Total									402502	45%	482,303.33	279,656.55	279,656.55	-	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Verification	6/1-25-9/30/25	Zane Networks	TPU Verification	Competitive	CW128050	Cheryl Dodd			1000128	55%	149,448.16	341,802.46	341,802.46	-	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Verification - Total									402502	45%	332,553.58	621,459.81	621,459.81	-	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Verification	10/12-4/5/31/25	Zane Networks	TPU Verification	Competitive	CW128050	Cheryl Dodd			1000128	55%	179,323.88	179,323.88	179,323.88	-	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Verification - Total									402502	45%	208,173.64	208,173.64	208,173.64	-	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Verification	10/12-4/5/31/25	Zane Networks	TPU Verification	Competitive	CW128050	Cheryl Dodd			1000128	55%	378,497.52	378,497.52	378,497.52	-	
100203	Health Care Operations Administration	70261	6000	Third Party Liability Contract - Verification - Total									402502	45%	45,555,501.89	63,009,633.28	63,009,633.28	8,172,664.86	
100205	Health Care Operations Administration	70262	6000	ASO Contract Admin	10/12-4/9/12/25	PCG	Administrative Svc Organization	Exempt	CW85552	Emilie Moore	\$1,907,902.00		10/0001	55%	1,091,346.30	2,722,869.63	2,722,869.63	193,329.00	
100205	Health Care Operations Administration	70262	6000	ASO Contract Admin - Total									402502	45%	838,555.50	2,252,347.88	2,252,347.88	158,175.00	
100205	Health Care Operations Administration	70262	6000	ASO Contract Admin	9/13-25-9/30/25	PCG	Administrative Svc Organization	Exempt	CW85552	Emilie Moore	\$1,122,096.67		10/0001	55%	61,715.32	144,887.88	144,887.88	351,580.00	
100205	Health Care Operations Administration	70262	6000	ASO Contract Admin - Total									402502	45%	50,494.35	115,544.63	115,544.63	-	
100205	Health Care Operations Administration	70262	6000	ASO Contract Admin	10/12-4/9/30/25	PCG	Administrative Svc Organization	Exempt	CW85552	Emilie Moore	\$1,122,096.67		10/0001	55%	112,139.67	263,431.90	263,431.90	-	
100205	Health Care Operations Administration	70262	6000	ASO Contract Admin - Total									402502	45%	2,820,114.67	5,268,659.00	5,268,659.00	351,580.00	
100205	Health Care Operations Administration	70262	6000	ASO Contract Admin - Total									402502	45%	47,575,213.56	62,179,623.25	62,179,623.25	8,524,114.66	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project	10/12-4/9/30/25	AVID - (POT16419-Jammy)	Consulting Services	Competitive	CW94253	Josef Waisfeld	\$175,000.00		10/0001	55%	2,904.00	96,250.00	96,250.00	2,904.00	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project	10/12-4/9/30/25	AVID - (POT16419-Jammy)	Consulting Services	Competitive	CW94253	Josef Waisfeld	\$175,000.00		10/0001	55%	2,376.00	78,750.00	78,750.00	2,376.00	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project - Total									402502	45%	5,280.00	175,000.00	175,000.00	5,280.00	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project - Total									402502	45%	857,507.70	1,072,500.00	1,072,500.00	-	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project - Total									402502	45%	773,992.21	872,500.00	872,500.00	-	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project - Total									402502	45%	1,719,104.50	1,954,000.00	1,954,000.00	-	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project - Total									402502	45%	113,246.33	113,246.33	113,246.33	-	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project - Total									402502	45%	92,656.88	92,656.88	92,656.88	-	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project - Total									402502	45%	208,962.41	208,962.41	208,962.41	-	
100207	Health Care Reform and Innovation Administration	70267	8000	Reform and Innovation Contractor for Focused Project - Total									402502	45%	1,234,284.99	2,234,962.41	2,234,962.41	5,280.00	
100208	Health Care Reform and Innovation Administration	70268	8000	State Level Registry (SLR) ARPA	10/12-4/9/30/25	Health Tech Solutions	Registly	Sole Source	CW110345	Edmund Koch	\$17,087.50		10/0001	25%	17,808.75	33,956.40	33,956.40	5,586.25	
100208	Health Care Reform and Innovation Administration	70268	8000	State Level Registry (SLR) ARPA	10/12-4/9/30/25	Health Tech Solutions	Registly	Sole Source	CW110345	Edmund Koch	\$17,087.50		10/0001	25%	180,278.75	385,427.60	385,427.60	60,276.25	
100208	Health Care Reform and Innovation Administration	70268	8000	State Level Registry (SLR) ARPA - Total									402502	75%	178,087.50	339,364.00	339,364.00	55,862.50	
100208	Health Care Reform and Innovation Administration	70268	8000	State Level Registry (SLR) ARPA	10/12-4/9/30/25	Health Tech Solutions	Registly	Sole Source	CW110345	Edmund Koch	\$17,087.50		10/0001	25%	45,250.00	45,250.00	45,250.00	1,795.20	
100208	Health Care Reform and Innovation Administration	70268	8000	State Level Registry (SLR) ARPA	10/12-4/9/30/25	Health Tech Solutions	Registly	Sole Source	CW110345	Edmund Koch	\$17,087.50		10/0001	25%	135,750.00	135,750.00	135,750.00	16,156.80	
100208	Health Care Reform and Innovation Administration	70268	8000	State Level Registry (SLR) ARPA - Total									402502	75%	-	181,000.00	181,000.00	17,952.00	
100208	Health Care Reform and Innovation Administration	70268	8000	State Level Registry (SLR) ARPA	10/12-4/9/30/25	Health Tech Solutions	Registly	Sole Source	CW110345	Edmund Koch	\$17,087.50		10/0001	25%	63,016.80	18,100.00	18,100.00	-	
100208	Health Care Reform and Innovation Administration	70268	8000	State Level Registry (SLR) ARPA	10/12-4/9/30/25	Health Tech Solutions	Registly	Sole Source	CW110345	Edmund Koch	\$17,087.50		10/0001	25%	151,599.20	162,900.00	162,900.00	-	
100208	Health Care Reform and Innovation Administration																		

Program Code	Program Name	Cost Center	Cost Center Title	Contract Name / Description	Period of Performance	Contract Service Provider	Purpose of Contract	Procurement Method (Bid or Sole Source)	Contract Number	DHCP Employee Responsible for the Contract (CA)	Original Contract Value	Modifications	Funding Source	FY26 Funding Split	FY25 Actuals	FY26 Approved Budget	FY26 Anticipated Cost	FY26 Expenditures thru 12/31/25	COMMENTS
100207	Health Care Reform and Innovation Administration	70267	8000	To support 1st time home visiting grants	10/1/24-9/30/25	Mary's CTR Maternal Child	Home Visiting First-Time Birthling Person Home Visitation		Grant		1010001	100%	1010001	100%	162,500.00	625,000.00	500,000.00	-	
				To support 1st time home visiting grants - Total											162,500.00	625,000.00	500,000.00	-	
100207	Health Care Reform and Innovation Administration	70267	8000	Transforming Maternal Health (TMatH)	10/1/24-9/30/25	Aval Systems (Contract)			4020002	100%	98,500.00	472,277.00	13,200.00						Aval expense
100207	Health Care Reform and Innovation Administration	70267	8000	Transforming Maternal Health (TMatH)	10/1/24-9/30/25	THD (Grants)	Support TMatH model grant		Federal Grant		4020002	100%		100,000.00	100,000.00				New Grant in FY26
100207	Health Care Reform and Innovation Administration	70267	8000	Transforming Maternal Health (TMatH)	10/1/24-9/30/25	Provider Payment (Medical Vendor Services)			4020002	100%	998,599.55	998,599.55	212,500.00						New Grant in FY26 - Provider incentive
				Transforming Maternal Health (TMatH) - Total							98,500.00	1,570,876.55	1,570,877.55	225,700.00	-				
100207	Health Care Reform and Innovation Administration	70267	8000	Continuity of Care Following Incarceration (CAA)	10/1/24-9/30/25	THD	Support CAA model grant		Federal Grant		4020002	100%	-	500,000.00	500,000.00	-			
				Continuity of Care Following Incarceration (CAA) - Total							-	500,000.00	500,000.00	-					
100207	Health Care Reform and Innovation Administration	70267	8000	Cell & Gown Therapy (CGT)	10/1/24-9/30/25	THD	Support CGT model grant		Federal Grant		4020002	100%	-	500,000.00	500,000.00	-			
				Cell & Gown Therapy (CGT) - Total							-	500,000.00	500,000.00	-					
				Total--Grants Program Cost Center							1,241,000.00	2,070,876.55	2,070,877.55	225,700.00	-				
				8000 Grants - TOTAL							7,642,897.65	14,576,482.55	14,851,483.55	225,700.00	-				
				8000 - GRAND TOTAL							9,659,946.05	19,733,748.96	19,608,749.96	364,794.50	-				
				TOTAL AGENCY							168,986,426.60	227,731,377.79	227,601,995.20	23,447,484.32	-				

15. Please provide a list of all Department of General Services work orders submitted in FY 2025 and FY 2026, 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 2026 (October 2025 - January 2026), 65 service tickets were submitted, 57 were completed, 1 still open, and 7 were rejected/cancelled.

In FY 2025 (October 2024 - September 2025), 223 service tickets were submitted, 189 were completed, 0 are still open, and 34 were rejected/cancelled.

	Work Order No	Building	Main Status	Date Requested	Date of Completion
1	798098	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/1/2024	10/8/2024
2	798265	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/1/2024	10/3/2024
3	798325	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/2/2024	10/7/2024
4	798364	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/2/2024	10/3/2024
5	798519	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/3/2024	10/7/2024
6	798702	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/4/2024	10/4/2024
7	798703	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/4/2024	10/4/2024
8	798911	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/7/2024	10/8/2024
9	799070	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/8/2024	10/8/2024
10	799067	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/8/2024	10/8/2024
11	799099	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/8/2024	10/8/2024
12	799026	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/8/2024	10/8/2024
13	799021	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/8/2024	10/9/2024
14	799379	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/10/2024	10/16/2024
15	799314	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/10/2024	10/21/2024

16	799367	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/10/2024	10/10/2024
17	799598	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/15/2024	10/16/2024
18	799611	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/15/2024	10/21/2024
19	799909	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/17/2024	10/29/2024
20	799935	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/17/2024	10/29/2024
21	800182	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/18/2024	10/18/2024
22	800454	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/22/2024	10/22/2024
23	800580	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/23/2024	10/23/2024
24	800517	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/23/2024	10/23/2024
25	800582	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/23/2024	10/28/2024
26	800684	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/24/2024	10/24/2024
27	801103	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/28/2024	10/29/2024
28	801174	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/29/2024	10/29/2024
29	801356	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	10/30/2024	10/30/2024
30	801313	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	10/30/2024	10/30/2024
31	801449	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/31/2024	10/31/2024
32	801742	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/4/2024	11/4/2024
33	802021	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/6/2024	11/8/2024
34	802207	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	11/7/2024	11/8/2024
35	802873	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/14/2024	11/14/2024

36	802932	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/15/2024	11/15/2024
37	803209	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/18/2024	5/8/2025
38	803130	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	11/18/2024	11/18/2024
39	803300	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/19/2024	11/19/2024
40	803518	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/20/2024	11/25/2024
41	804007	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/26/2024	12/6/2024
42	804155	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/27/2024	12/6/2024
43	804461	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/3/2024	12/3/2024
44	805121	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/5/2024	12/6/2024
45	805561	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/10/2024	12/17/2024
46	805594	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/10/2024	12/18/2024
47	805630	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/11/2024	12/17/2024
48	806200	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/17/2024	12/17/2024
49	806246	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/17/2024	12/18/2024
50	806505	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/20/2024	12/30/2024
51	806980	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	1/2/2025	1/15/2025
52	807404	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/7/2025	1/23/2025
53	807587	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	1/8/2025	1/8/2025
54	807472	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	1/8/2025	1/13/2025
55	807588	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	1/8/2025	1/15/2025

56	807556	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	1/8/2025	1/9/2025
57	807551	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	1/8/2025	1/9/2025
58	807767	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/9/2025	1/15/2025
59	807683	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	1/9/2025	1/10/2025
60	808082	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/13/2025	1/16/2025
61	808464	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/15/2025	1/15/2025
62	808370	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/15/2025	1/15/2025
63	808603	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/16/2025	1/16/2025
64	808944	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/21/2025	1/21/2025
65	808947	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/21/2025	1/23/2025
66	809106	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	1/21/2025	1/22/2025
67	809345	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/22/2025	1/22/2025
68	809415	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	1/23/2025	1/23/2025
69	809474	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/23/2025	1/24/2025
70	809437	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/23/2025	1/24/2025
71	809467	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/23/2025	1/27/2025
72	809416	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/23/2025	1/27/2025
73	809742	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	1/24/2025	1/27/2025
74	810218	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	1/29/2025	1/29/2025
75	810365	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/30/2025	1/30/2025

76	810285	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	1/30/2025	1/30/2025
77	810839	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/4/2025	2/6/2025
78	810884	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/4/2025	2/5/2025
79	810861	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/4/2025	2/5/2025
80	811058	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	2/5/2025	2/5/2025
81	811057	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	2/5/2025	2/5/2025
82	810961	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/5/2025	2/18/2025
83	811101	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/6/2025	2/6/2025
84	811165	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/6/2025	2/7/2025
85	811140	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/6/2025	2/6/2025
86	811272	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/7/2025	2/7/2025
87	811464	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/10/2025	2/11/2025
88	811610	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/11/2025	2/12/2025
89	811616	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/11/2025	2/18/2025
90	811684	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/12/2025	2/13/2025
91	811764	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/13/2025	2/17/2025
92	811828	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/13/2025	2/17/2025
93	811786	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/13/2025	2/17/2025
94	811978	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/14/2025	2/19/2025
95	812064	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/18/2025	2/18/2025

96	812082	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/18/2025	2/19/2025
97	812270	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	2/19/2025	5/8/2025
98	812307	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	2/19/2025	2/19/2025
99	812795	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/21/2025	2/25/2025
100	813447	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/26/2025	2/27/2025
101	813308	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/26/2025	2/27/2025
102	813425	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	2/26/2025	5/8/2025
103	813493	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/27/2025	3/4/2025
104	813655	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	2/28/2025	3/4/2025
105	813638	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	2/28/2025	2/28/2025
106	813808	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/3/2025	3/4/2025
107	814403	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/7/2025	3/13/2025
108	814391	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/7/2025	3/13/2025
109	814428	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/7/2025	3/19/2025
110	814397	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	3/7/2025	3/7/2025
111	815064	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/13/2025	3/13/2025
112	815094	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/13/2025	3/19/2025
113	815034	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/13/2025	3/19/2025
114	815091	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	3/13/2025	6/5/2025
115	815183	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	3/14/2025	3/14/2025

116	815492	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/18/2025	3/19/2025
117	815406	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	3/18/2025	3/18/2025
118	815493	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	3/18/2025	3/18/2025
119	815560	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/19/2025	4/2/2025
120	815531	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/19/2025	4/2/2025
121	815633	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/19/2025	4/2/2025
122	815690	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/20/2025	4/2/2025
123	815804	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/21/2025	4/2/2025
124	816237	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/25/2025	4/2/2025
125	816126	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	3/25/2025	4/2/2025
126	820429	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/5/2025	5/23/2025
127	820671	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/7/2025	5/19/2025
128	820665	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/7/2025	5/27/2025
129	820864	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	5/8/2025	5/8/2025
130	820807	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/8/2025	5/19/2025
131	820744	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/8/2025	5/23/2025
132	820919	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/9/2025	5/19/2025
133	820922	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/9/2025	5/23/2025
134	821089	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/12/2025	5/19/2025
135	821183	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	5/13/2025	5/13/2025

136	821184	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/13/2025	5/19/2025
137	821347	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/14/2025	5/19/2025
138	821358	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/14/2025	8/11/2025
139	821786	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/16/2025	5/27/2025
140	821764	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/16/2025	6/4/2025
141	821892	OJS BUILDING (Marion S. Barry, Jr. Building)	Closed	5/19/2025	6/4/2025
142	821900	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/19/2025	5/19/2025
143	822219	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/21/2025	5/21/2025
144	822682	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/28/2025	5/28/2025
145	822685	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	5/28/2025	5/28/2025
146	823154	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/2/2025	6/5/2025
147	823445	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	6/4/2025	6/4/2025
148	823382	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/4/2025	6/4/2025
149	823518	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/5/2025	6/5/2025
150	824541	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/16/2025	6/17/2025
151	824481	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/16/2025	6/16/2025
152	824609	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/17/2025	6/17/2025
153	824767	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	6/18/2025	6/17/2025
154	824768	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	6/18/2025	6/18/2025
155	825229	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/23/2025	6/24/2025

156	825425	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/24/2025	6/25/2025
157	825331	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/24/2025	6/25/2025
158	825347	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/24/2025	8/11/2025
159	825367	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/24/2025	6/25/2025
160	825337	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/24/2025	6/25/2025
161	825615	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/25/2025	6/25/2025
162	825561	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/25/2025	6/27/2025
163	825513	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/25/2025	6/25/2025
164	825756	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/26/2025	6/27/2025
165	825751	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/26/2025	6/27/2025
166	825810	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/26/2025	6/30/2025
167	825945	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/27/2025	6/30/2025
168	825888	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/27/2025	6/30/2025
169	825895	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/27/2025	6/30/2025
170	825891	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/27/2025	7/1/2025
171	826001	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	6/30/2025	6/30/2025
172	826264	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/1/2025	7/2/2025
173	826439	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/2/2025	7/3/2025
174	826388	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/2/2025	7/3/2025
175	826532	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/3/2025	7/8/2025

176	826659	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/7/2025	7/7/2025
177	826971	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/9/2025	7/10/2025
178	826986	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/9/2025	7/10/2025
179	827216	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	7/10/2025	7/10/2025
180	827248	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/10/2025	7/10/2025
181	827221	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/10/2025	7/16/2025
182	827537	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/11/2025	7/16/2025
183	827413	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/11/2025	7/23/2025
184	827663	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	7/14/2025	7/14/2025
185	827651	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/14/2025	7/16/2025
186	827677	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/14/2025	7/22/2025
187	827715	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	7/14/2025	7/14/2025
188	828746	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/22/2025	7/23/2025
189	828820	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/22/2025	7/23/2025
190	828946	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/23/2025	7/23/2025
191	829177	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/24/2025	7/25/2025
192	829105	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/24/2025	7/25/2025
193	829130	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/24/2025	7/25/2025
194	829362	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/25/2025	7/28/2025
195	829619	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/29/2025	7/29/2025

196	829630	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/29/2025	7/29/2025
197	829747	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/30/2025	7/30/2025
198	829967	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	7/31/2025	8/6/2025
199	830121	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	8/1/2025	8/6/2025
200	830652	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	8/5/2025	8/6/2025
201	830553	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	8/5/2025	8/11/2025
202	830755	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	8/6/2025	8/6/2025
203	830720	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	8/6/2025	8/6/2025
204	830840	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	8/7/2025	8/7/2025
205	830844	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	8/7/2025	8/7/2025
206	830887	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	8/7/2025	8/7/2025
207	836233	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/16/2025	9/18/2025
208	836420	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/17/2025	9/18/2025
209	836300	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/17/2025	9/22/2025
210	836692	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/19/2025	9/22/2025
211	836810	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	9/22/2025	9/22/2025
212	837046	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/23/2025	9/24/2025
213	837143	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	9/24/2025	9/24/2025
214	837191	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/24/2025	9/30/2025
215	837258	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/25/2025	9/25/2025

216	837235	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/25/2025	9/30/2025
217	837232	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/25/2025	9/30/2025
218	837442	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	9/26/2025	9/26/2025
219	837449	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/26/2025	9/26/2025
220	837687	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	9/29/2025	9/29/2025
221	837634	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/29/2025	9/30/2025
222	837762	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/30/2025	10/1/2025
223	837756	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	9/30/2025	10/7/2025
224	838198	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/2/2025	10/7/2025
225	838200	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/2/2025	10/7/2025
226	838203	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/2/2025	10/7/2025
227	838326	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	10/3/2025	10/3/2025
228	838329	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/3/2025	10/7/2025
229	838602	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/7/2025	10/9/2025
230	838753	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/8/2025	10/8/2025
231	838727	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/8/2025	10/8/2025
232	838729	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/8/2025	10/9/2025
233	838922	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/9/2025	10/9/2025
234	838970	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/9/2025	10/14/2025
235	839266	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/14/2025	10/16/2025

236	839185	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/14/2025	10/16/2025
237	839183	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/14/2025	10/16/2025
238	839126	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/14/2025	10/24/2025
239	839355	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/15/2025	10/16/2025
240	839545	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/16/2025	10/9/2025
241	839546	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/16/2025	10/17/2025
242	839703	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/17/2025	11/24/2025
243	839776	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/20/2025	10/20/2025
244	839930	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/21/2025	10/22/2025
245	840770	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/28/2025	10/30/2025
246	840764	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/28/2025	10/30/2025
247	840825	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/28/2025	10/30/2025
248	840889	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/29/2025	11/7/2025
249	840963	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	10/29/2025	11/5/2025
250	841358	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/3/2025	11/5/2025
251	841493	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	11/4/2025	11/4/2025
252	841529	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/4/2025	11/5/2025
253	841592	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/5/2025	11/5/2025
254	841708	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/5/2025	11/6/2025
255	841844	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/6/2025	11/7/2025

256	841958	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/7/2025	11/13/2025
257	842105	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	11/10/2025	11/10/2025
258	842106	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/10/2025	11/17/2025
259	842109	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/10/2025	11/18/2025
260	842248	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/12/2025	11/17/2025
261	842471	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/13/2025	11/13/2025
262	842458	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/13/2025	11/13/2025
263	842450	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/13/2025	11/18/2025
264	842664	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/14/2025	11/18/2025
265	842783	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/17/2025	11/18/2025
266	843170	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/19/2025	11/20/2025
267	843136	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/19/2025	12/4/2025
268	843342	OJS BUILDING (Marion S. Barry, Jr. Building)	Rejected	11/20/2025	11/20/2025
269	843629	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/24/2025	11/24/2025
270	843690	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/24/2025	12/9/2025
271	843802	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	11/25/2025	11/25/2025
272	843803	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	11/25/2025	12/2/2025
273	844020	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/1/2025	12/4/2025
274	844232	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/2/2025	12/4/2025
275	844418	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/3/2025	12/3/2025

276	844566	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/3/2025	12/4/2025
277	844691	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/4/2025	12/4/2025
278	844844	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/5/2025	12/8/2025
279	845241	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/9/2025	12/10/2025
280	845291	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/9/2025	12/11/2025
281	845294	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/9/2025	12/18/2025
282	846065	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	12/16/2025	12/16/2025
283	846064	OJS BUILDING (Marion S. Barry, Jr. Building)	Cancelled	12/16/2025	12/16/2025
284	846203	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/17/2025	12/18/2025
285	846238	OJS BUILDING (Marion S. Barry, Jr. Building)	Issued and in Process	12/17/2025	12/18/2025
286	846783	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/24/2025	12/26/2025
287	846830	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/26/2025	12/29/2025
288	847114	OJS BUILDING (Marion S. Barry, Jr. Building)	Completed	12/31/2025	12/31/2025

Items a and b

Fund Number	Fund Name	Revenue Source / Funds Generating Program
1060128	MEDICAID COLLECTIONS-3RD PARTY LIABILITY	Reimbursement from other parties (commercial health insurance, auto & casualty insurance, estate recovery, etc.) liable for the cost of care for Medicaid beneficiaries, as well as recoveries from providers for Medicaid fraud and abuse.
1060132	BILL OF RIGHTS- (GRIEVANCE & APPEALS)	Assessments on commercial health insurers for the cost of the Health Care Ombudsman's Office.
1060138	ASSESSMENT FUND	Provider enrollment fees.
1060386	INDIVIDUAL INSUR MKT AFFORD & STABILITY	Penalties for non-compliance with the District's individual insurance mandate.

FY 2025 Items c, d, and e

1060128	MEDICAID COLLECTIONS-3RD PARTY LIABILITY				
Program (Parent Level)	Program (Parent Level 2) Description	Account Class	Account Class Description	EXPENSE	REVENUE
AMP070	HEALTH CARE OPERATIONS	701100B	CONTINUING FULL TIME	\$223,635.94	
AMP070	HEALTH CARE OPERATIONS	701300B	ADDITIONAL GROSS PAY	\$238.62	
AMP070	HEALTH CARE OPERATIONS	701400B	FRINGE BENEFITS - CURR PERSONNEL	\$52,184.68	
AMP070	HEALTH CARE OPERATIONS	713000B	CONTRACTUAL SERVICES	\$472,211.33	
HS0027	PROVIDER SERVICES	652000B	MISCELLANEOUS INCOME		-\$1,965,493.20
HS0027	PROVIDER SERVICES	714000B	GOVERNMENT SUBSIDIES & GRANTS	\$1,102,749.00	
PRG000	NO PROGRAM	652000B	MISCELLANEOUS INCOME		-\$140,515.13
PRG000	NO PROGRAM	719000B	OTHER FINANCING USES	\$3,319,850.56	
1060128 Total				\$5,170,870.13	-\$2,106,008.33

Transfer to Local. DC Act 26-142

1060132	BILL OF RIGHTS-(GRIEVANCE & APPEALS)				
Program (Parent Level)	Program (Parent Level 2) Description	Account Class	Account Class Description	EXPENSE	REVENUE
AFO000	AGENCY FINANCIAL OPERATIONS	715000B	OTHER EXPENSES	\$0.00	
AMP000	AGENCY MANAGEMENT PROGRAM	652000B	MISCELLANEOUS INCOME		-\$2,614,822.89
AMP000	AGENCY MANAGEMENT PROGRAM	701100B	CONTINUING FULL TIME	\$1,009,744.60	
AMP000	AGENCY MANAGEMENT PROGRAM	701200B	CONTINUING FULL TIME - OTHER	\$103,357.80	
AMP000	AGENCY MANAGEMENT PROGRAM	701300B	ADDITIONAL GROSS PAY	\$1,633.06	
AMP000	AGENCY MANAGEMENT PROGRAM	701400B	FRINGE BENEFITS - CURR PERSONNEL	\$249,697.55	
AMP000	AGENCY MANAGEMENT PROGRAM	711000B	SUPPLIES & MATERIALS	\$1,747.60	
AMP000	AGENCY MANAGEMENT PROGRAM	713000B	CONTRACTUAL SERVICES	\$342,892.22	
AMP066	HEALTH CARE DELIVERY MANAGEMENT	713000B	CONTRACTUAL SERVICES	-\$88,966.70	
AMP067	LONG TERM CARE PROGRAM	701100B	CONTINUING FULL TIME	-\$4,487.01	
HS0024	HEALTH CARE ANALYTICS	713000B	CONTRACTUAL SERVICES	-\$12,588.49	
HS0026	PROGRAM OVERSIGHT	713000B	CONTRACTUAL SERVICES	-\$7,562.06	
PRG000	NO PROGRAM	719000B	OTHER FINANCING USES	\$1,720,097.43	
1060132 Total				\$3,315,566.00	-\$2,614,822.89

Transfer to Local. DC Act 26-142

1060138	ASSESSMENT FUND				
Program (Parent Level)	Program (Parent Level 2) Description	Account Class	Account Class Description	EXPENSE	REVENUE
AMP000	AGENCY MANAGEMENT PROGRAM	652000B	MISCELLANEOUS INCOME		-\$46,321.00
PRG000	NO PROGRAM	719000B	OTHER FINANCING USES	\$37,028.71	
1060138 Total				\$37,028.71	-\$46,321.00

Transfer to Local. DC Act 26-142

1060386	INDIVIDUAL INSUR MKT AFFORD & STABILITY				
Program (Parent Level)	Program (Parent Level 2) Description	Account Class	Account Class Description	EXPENSE	REVENUE
AFO000	AGENCY FINANCIAL OPERATIONS	713000B	CONTRACTUAL SERVICES	-\$7.29	
HS0026	PROGRAM OVERSIGHT	652000B	MISCELLANEOUS INCOME		-\$6,618,939.34
PRG000	NO PROGRAM	719000B	OTHER FINANCING USES	\$11,793,836.71	
1060386 Total				\$11,793,829.42	-\$6,618,939.34

Transfer to Local. DC Act 26-142

FY 2026 Q1 Items c, d, and e

1060128	MEDICAID COLLECTIONS-3RD PARTY LIABILITY				
Program (Parent Level 2)	Program (Parent Level 2) Description	Account Class	Account Class Description	EXPENSE	REVENUE
AMP070	HEALTH CARE OPERATIONS	701100B	CONTINUING FULL TIME	\$62,215.85	
AMP070	HEALTH CARE OPERATIONS	701400B	FRINGE BENEFITS - CURR PERSONNEL	\$13,213.51	
AMP070	HEALTH CARE OPERATIONS	713000B	CONTRACTUAL SERVICES	\$39,614.90	
HS0027	PROVIDER SERVICES	652000B	MISCELLANEOUS INCOME		-\$1,990,622.40
1060128 Total				\$115,044.26	-\$1,990,622.40

1060132	BILL OF RIGHTS-(GRIEVANCE & APPEALS)				
Program (Parent Level 2)	Program (Parent Level 2) Description	Account Class	Account Class Description	EXPENSE	REVENUE
AMP000	AGENCY MANAGEMENT PROGRAM	701100B	CONTINUING FULL TIME	\$258,211.97	
AMP000	AGENCY MANAGEMENT PROGRAM	701200B	CONTINUING FULL TIME - OTHERS	\$23,801.15	
AMP000	AGENCY MANAGEMENT PROGRAM	701300B	ADDITIONAL GROSS PAY	\$2,631.82	
AMP000	AGENCY MANAGEMENT PROGRAM	701400B	FRINGE BENEFITS - CURR PERSONNEL	\$61,805.70	
AMP000	AGENCY MANAGEMENT PROGRAM	701500B	OVERTIME PAY	\$0.00	
AMP000	AGENCY MANAGEMENT PROGRAM	713000B	CONTRACTUAL SERVICES	-\$22,399.77	
1060132 Total				\$324,050.87	

1060138	ASSESSMENT FUND				
Program (Parent Level 2)	Program (Parent Level 2) Description	Account Class	Account Class Description	EXPENSE	REVENUE
AMP000	AGENCY MANAGEMENT PROGRAM	652000B	MISCELLANEOUS INCOME		-\$62,071.00
1060138 Total					-\$62,071.00

1060386	INDIVIDUAL INSUR MKT AFFORD & STABILITY				
Program (Parent Level 2)	Program (Parent Level 2) Description	Account Class	Account Class Description	EXPENSE	REVENUE
HS0026	PROGRAM OVERSIGHT	652000B	MISCELLANEOUS INCOME		-\$1,225,001.71
1060386 Total					-\$1,225,001.71

16. Provide a complete accounting of all DHCF's Special Purpose Revenue Funds for FY 2025 and FY 2026, to date. Please include the following:

- a. **Revenue source name and code;**
- b. **Description of the program that generates the funds;**
- c. **Cost center that the revenue in each special purpose revenue fund supports;**
- d. **Total amount of funds generated by each source or program in FY 2025 and FY 2026, to date;**
- e. **Expenditure of funds in FY 2025 and FY 2026 to date, including reprogramming, and purpose of expenditure; and**
- f. **Fund balance at the end of FY 2025 and FY 2026, to date.**

Response:

- Please see Q16 – attachment 1 tab 'Items a & b' for the response to items a and b above.
- Please see Q16 – attachment 1 tab 'FY 2025 Items c d & e' for the FY 2025 responses to items c, d, and e above. Please note this is an extract of a DIFS report in which revenue is shown as a negative number.
- Please see Q16 – attachment 1 tab 'FY 2026 Q1 Items c d & e' for the FY 2026 Q1 responses to items c, d, and e above. Please note this is an extract of a DIFS report in which revenue is shown as a negative number.
- In response to item f, the Assessment Fund had an FY 2025 year-end fund balance of \$52,210.00, and the Individual Insurance Market Affordability & Stability fund had an FY 2025 year-end fund balance of \$1,323,646.63. The other Special Purpose Revenue funds had year-end fund balances of \$0.00.

FY 2025 Capital Budgets & Spending

Fund	Fund Description	Project#	Project Description	FY 2025 Revised Budget	FY 2025 Expenditures & Obligations
3030300	LONG TERM / G.O. / I.T. BONDS	100464	HT0.CM102C.REPLACE CASE MANAGEMENT SYSTEM	\$136,635.85	\$0.00
		100466	HT0.DIM01C.ENTERPRISE DATA INTEGRATION SYSTEM/MEDI	\$1,338,536.00	\$0.00
		100469	HT0.MPM03C.MMIS UPGRADED SYSTEM	\$10,456,495.04	\$3,437,969.30
		100470	HT0.MPM05C.MEDICAID DATA WAREHOUSE- GO BOND	\$0.00	\$0.00
		100471	HT0.PBM01C.PHARMACY BENEFIT MANAGER SYSTEM REFRESH	\$360,000.00	\$0.00
		100472	HT0.PDM01C.PROVIDER DATA MANAGEMENT SYSTEM REFRESH	\$400,000.00	\$0.00
		100473	HT0.UMC02C.UNITED MEDICAL CENTER IMPROVEMENTS	\$8,898,566.01	\$0.00
		100474	HT0.UMV01C.SAINT ELIZABETHS MEDICAL CENTER	\$2,298,456.01	\$0.00
3030300 Total				\$23,888,688.91	\$3,437,969.30
3030301	PAY AS YOU GO	100470	HT0.MPM05C.MEDICAID DATA WAREHOUSE- GO BOND	\$0.00	\$0.00
		100473	HT0.UMC02C.UNITED MEDICAL CENTER IMPROVEMENTS	\$1,750,529.83	\$0.00
		100474	HT0.UMV01C.SAINT ELIZABETHS MEDICAL CENTER	\$1,000,000.00	\$0.00
3030301 Total				\$2,750,529.83	\$0.00
3030304	SHORT - TERM BONDS	100464	HT0.CM102C.REPLACE CASE MANAGEMENT SYSTEM	\$124,762.90	\$0.00
		100465	HT0.CM103C.CLINICAL CASE MANAGEMENT SYSTEM REFRESH	\$400,000.00	\$0.00
		100466	HT0.DIM01C.ENTERPRISE DATA INTEGRATION SYSTEM/MEDI	\$2,334,809.36	\$0.00
		100468	HT0.MES23C.DCAS RELEASE 3	\$4,950,867.24	\$165,607.61
			(blank)	-\$52,550.00	\$0.00
		100469	HT0.MPM03C.MMIS UPGRADED SYSTEM	\$4,251,387.00	\$0.00
3030304 Total				\$12,009,276.50	\$165,607.61
3030309	TAXABLE BONDS	100474	HT0.UMV01C.SAINT ELIZABETHS MEDICAL CENTER	\$6,978,814.86	\$0.00
3030309 Total				\$6,978,814.86	\$0.00
3035350	CAPITAL - FEDERAL GRANTS	100464	HT0.CM102C.REPLACE CASE MANAGEMENT SYSTEM	\$900,641.43	\$0.00
		100465	HT0.CM103C.CLINICAL CASE MANAGEMENT SYSTEM REFRESH	\$3,600,000.00	\$0.00
		100466	HT0.DIM01C.ENTERPRISE DATA INTEGRATION SYSTEM/MEDI	\$10,501,194.21	\$0.00
		100467	HT0.MES12C.MES - FEDERAL MATCH	\$27,241,266.50	\$0.00
		100468	HT0.MES23C.DCAS RELEASE 3	\$5,863,582.38	\$1,422,955.83
		100469	HT0.MPM03C.MMIS UPGRADED SYSTEM	\$69,618,878.10	\$30,941,723.70
		100470	HT0.MPM05C.MEDICAID DATA WAREHOUSE- GO BOND	\$2,119,125.27	\$0.00
3035350 Total				\$119,844,687.89	\$32,364,679.53
Grand Total				\$165,471,997.99	\$35,968,256.44

FY 2026 Q1 Capital Budgets & Spending

Fund	Fund Description	Project#	Project Description	FY 2026 Revised Budget	FY 2026 Q1 Expenditures & Obligations
3030300	LONG TERM / G.O. / I.T. BONDS	100464	HT0.CM102C.REPLACE CASE MANAGEMENT SYSTEM	\$136,635.85	\$26,749.14
		100466	HT0.DIM01C.ENTERPRISE DATA INTEGRATION SYSTEM/MEDI	\$1,338,536.00	\$0.00
		100469	HT0.MPM03C.MMIS UPGRADED SYSTEM	\$7,018,525.74	\$3,047,714.79
		100470	HT0.MPM05C.MEDICAID DATA WAREHOUSE- GO BOND	\$0.00	\$0.00
		100473	HT0.UMC02C.UNITED MEDICAL CENTER IMPROVEMENTS	\$8,898,566.01	\$5,897,446.08
3030300 Total				\$17,392,263.60	\$8,971,910.01
3030301	PAY AS YOU GO	100470	HT0.MPM05C.MEDICAID DATA WAREHOUSE- GO BOND	\$0.00	\$0.00
		100473	HT0.UMC02C.UNITED MEDICAL CENTER IMPROVEMENTS	\$1,750,529.83	\$1,702,216.66
		100474	HT0.UMV01C.SAINT ELIZABETHS MEDICAL CENTER	\$1,000,000.00	\$0.00
3030301 Total				\$2,750,529.83	\$1,702,216.66
3030304	SHORT - TERM BONDS	100464	HT0.CM102C.REPLACE CASE MANAGEMENT SYSTEM	\$124,762.90	\$0.00
		100465	HT0.CM103C.CLINICAL CASE MANAGEMENT SYSTEM REFRESH	\$400,000.00	\$0.00
		100466	HT0.DIM01C.ENTERPRISE DATA INTEGRATION SYSTEM/MEDI	\$2,334,809.36	\$0.00
		100468	HT0.MES23C.DCAS RELEASE 3	\$2,960,606.47	\$2,376,039.31
			(blank)	-\$30,682.70	\$0.00
		100469	HT0.MPM03C.MMIS UPGRADED SYSTEM	\$4,251,387.00	\$0.00
3030304 Total				\$10,040,883.03	\$2,376,039.31
3030309	TAXABLE BONDS	100474	HT0.UMV01C.SAINT ELIZABETHS MEDICAL CENTER	-\$182,449.63	\$0.00
3030309 Total				-\$182,449.63	\$0.00
3035350	CAPITAL - FEDERAL GRANTS	100464	HT0.CM102C.REPLACE CASE MANAGEMENT SYSTEM	\$900,641.43	\$21,885.66
		100465	HT0.CM103C.CLINICAL CASE MANAGEMENT SYSTEM REFRESH	\$3,600,000.00	\$0.00
		100466	HT0.DIM01C.ENTERPRISE DATA INTEGRATION SYSTEM/MEDI	\$10,501,194.21	\$0.00
		100467	HT0.MES12C.MES - FEDERAL MATCH	\$24,566,293.40	-\$3,514.06
			(blank)	\$22,849.02	\$0.00
		100468	HT0.MES23C.DCAS RELEASE 3	\$4,151,186.56	\$5,208,265.48
		100469	HT0.MPM03C.MMIS UPGRADED SYSTEM	\$38,677,154.40	\$27,429,432.91
			(blank)	\$657,942.00	\$0.00
		100470	HT0.MPM05C.MEDICAID DATA WAREHOUSE- GO BOND	\$2,119,125.27	\$0.00
3035350 Total				\$85,196,386.29	\$32,656,069.99
Grand Total				\$115,197,613.12	\$45,706,235.97

17. Please provide the DHCF capital budgets for FY 2025 and FY 2026, to date, including the amount budgeted and actually spent. In addition, please provide an update on all capital projects undertaken in FY 2025 and FY 2026, to date.

Response:

Please see Q17 – attachment 1.

19. Please identify potential areas where spending pressures may exist in the agency in FY 2026. Please provide a detailed narrative of the spending pressure, including any steps that are being taken to minimize the impact on the FY 2027 budget.

Response:

At this time, DHCF does not project spending pressures for FY 2026.

20. Did DHCF meet the key performance indicators set forth in the performance plan for FY 2025? For any performance indicators that were not met, please provide a narrative description of why they were not met, and corrective actions taken.

Response:

There were three key performance indicators for FY25 that were not met by the agency.

1. Number of households served by Produce RX

We believe our original target reflected expectations that exceeded what historical performance supports, and we are adjusting the KPI accordingly. A key barrier to meeting the initial target is the program model's reliance on clinic partners to enroll participants, which limits our ability to directly influence enrollment volume. Additionally, the summer slowdown in clinic visits significantly reduced enrollment opportunities in Q4 2025, further contributing to the gap between projected and actual performance.

2. Percent of Medicaid renewals as a result of the passive renewals process.

This target was increased in FY25. The reason that our passive percentage for 2025 Q3 and 2025 Q4 are lower than prior quarters is largely due to two factors: (1) passive renewal rates tend to be lower in spring and summer months; (2) there was an eligibility system change that decreased the number of beneficiaries who could receive a passive renewal beginning with those due in April 2025. For these reasons we are reversing the target to 70% based on historical performance and document trends.

3. Percent of Medicaid Elderly and Persons with Physical Disabilities Home and Community-Based Waiver complaints investigated within 7 days of receipt.

LTCA previously used DHCF's legacy CSTS system and Ombudsman data to manage complaints, but manual routing limited efficiency and responsiveness. To improve operations, LTCA expanded use of the electronic Programmatic Provider Report (ePPR), a centralized ticketing system for tracking, assigning, and resolving LTSS complaints. Full adoption began in July 2025/Q4. The ePPR now captures complaints from all inbound channels, including the LTCA hotline and OMB, which submits unclassified issues directly. As staff adjust to the system and rising complaint volume, compliance is expected to improve next quarter.

**DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

General Question

22. For each Board, Commission, or Working Group overseen by DHCF, please provide:

- a. An updated list of members, including when their term started and ends;**
- b. A list of any vacant positions;**
- c. Dates of meetings held in FY 2025 and scheduled for FY 2026, including any publicly available minutes; and**
- d. Name and contact information of DHCF staff person who is point of contact/oversees the Board/Commission/Working Group.**

Response:

1. An updated list of members, including when their term started and ends

Member Name	Seat	Term
Dr. Jaclyn Kline	Medical Provider	12/2/2025 - 6/25/2027
Dr. Eric Marshall	Medical Provider	6/25/2018 - 6/25/2027
Mr. Darryl Stewart	DC Nurses Association	8/6/2024 - 6/25/2027
Mr. Justin Palmer	DC Hospital Association	6/25/2012 - 6/25/2027
Ms. Donna Ramos-Johnson	DC Primary Care Association	6/25/2016 - 6/25/2027
Ms. Alice Leiter	Public Member with health care or IT experience	6/25/2019 - 6/25/2028
Dr. James Crowe	Public Member	10/19/2023 - 6/25/2027
Ms. Nancy Ware	Public Member	12/2/2025 - 6/25/2027
Ms. Sherilyn Pruitt	Public Member	12/2/2025 - 6/25/2027
Ms. Kelli Johnson	Public Member	12/2/2025 - 6/25/2027
Mx. Deniz Soyer – HIE Policy Board Chair	Department of Health Care Finance (DHCF)	1/30/2023 - 1/2/2027

Ms. Melisa Byrd	Department of Health Care Finance (DHCF)	1/1/2019 - 1/2/2027
Dr. Barbara Bazron	Department of Behavioral Health (DBH)	1/1/2019 - 1/2/2027
Mr. Santiago Gonzalez-Irizarry	Department of Health (DOH)	12/2/2025 - 1/2/2027
Mr. Bryan Harrison – Ex-Officio, Non-Voting	Office of the Deputy Mayor for Health and Human Services (DMHHS)	1/1/2019 - 1/2/2027

2. A list of any vacant positions;

Member Name	Seat
Vacant	Medical Provider
Vacant	Medical Provider
Vacant	Medical Provider
Vacant	Representative from a Health Plan
Vacant	Medical Society
Vacant	Office of the Chief Technology Officer (OCTO)
Vacant	Department of Human Services (DHS)

3. Dates of meetings held in FY 2025 and scheduled for FY 2026, including any publicly available minutes; and

FY25 Meetings Held:

- October 24, 2024
- January 30, 2025
- April 24, 2025
- July 24, 2025

FY26 Meetings Held/Scheduled:

- October 23, 2025
- February 18, 2026
- May 21, 2026
- September 17, 2026

Records of meetings and materials are publicly available here:
<https://dhcf.dc.gov/dchiepb>

- 4. Name and contact information of DHCF staff person who is point of contact/oversees the Board/Commission/Working Group.**

Iesha Reid, iesha.reid@dc.gov

Q23

1. Fiscal Year 2024 Single Audit Findings, June 2025
 - a. Single Audit Medicaid Eligibility Finding and DHCF Corrective Action
 - i. Finding: Applications were not timely processed in 3 of 132 tested files.
 - ii. DHCF Corrective Action: The DCAS Division utilizes a “Pending Summary Report” (PSR) to identify applications pending determination for 30 days. Previously, this report was reviewed by applicable management on a weekly basis. In response to this finding, DCAS has increased the frequency of review of the PSR from weekly to daily. The effective date of this new cadence was October 9, 2025.
2. DC OIG Audit of D.C. Medicaid Eligibility
 - a. Scope: The scope of this audit was to review DHCF and DHS’ internal control over Medicaid eligibility determinations during the Public Health Emergency and unwinding of continuous coverage from April 1, 2023-June 30, 2024.
 - b. Finding: In 7 out of 47 cases, the DCAS system did not consistently reflect accurate eligibility status.
 - c. DHCF Response: DHCF disagreed with this finding. DCAS’ categorization of “Active” simply indicates that a public assistance application has been initiated. Notwithstanding, as part of the Commanding Case Closure Initiative, DHCF will provide refresher training to staff on the appropriate procedures for proper case closure and will incorporate a check for cases with an active status but no eligibility in the supervisory review process.
3. DC OIG Audit of the Medicaid Managed Care Program
 - a. Scope: DHCF’s oversight of the Medicaid Managed Care health service delivery system.
 - b. The DC OIG noted findings across the following 5 areas of oversight:
 - i. Oversight
 - ii. Data Management
 - iii. Program Integrity
 - iv. Access and Delivery
 - v. Contract Administration
 - c. Oversight Findings and Responses
 - i. Finding: Policies and Procedures for Monitoring MCOs Were Incomplete.
 1. Recommendation: Develop and implement comprehensive policies and procedures for all monitoring divisions including detailed guidance on using oversight dashboards and monitoring tools to effectively assess cost reduction and health care access.
 2. DHCF Response: DHCF disagrees in part with this finding.
 - a. DHCF’s managed care division does in fact has a well-established and documented compliance monitoring program in place, but DHCF agrees that broader policies and procedures across all divisions could further strengthen the managed care program.

- b. As of July 2025, DHCF is in the process of reviewing the suite of activities that comprise its managed care compliance monitoring program and identifying the corresponding policies and procedures that need to be strengthened.
 - c. Estimated Completion Date: By March 1, 2026, DHCF will have adopted the final policies and procedures that reflect its compliance monitoring program.
 - ii. Finding: MCO Contracts Contained Incomplete Overpayment Recovery and Retention Policies.
 - 1. DHCF Response: DHCF disagrees with this finding.
 - a. DHCF is already in compliance with 42 C.F.R. Sec. 438.608(d)(3). The applicable contract language states: C.5.33.1.6: “The Contractor shall submit *monthly* reports and a comprehensive *annual* report in a format determined by DHCF, on its recovery of overpayments, in accordance with 42 C.F.R. Sec. 438.608(d)(3),” and C.5.33.1.7: “The Contractor shall have retention policies for the treatment of recoveries of all overpayments from the Contractor to a Provider, including specifically a retention policy for the treatment of recoveries of overpayments due to fraud, waste, or abuse in accordance with 42 C.F.R. § 438.608(d). Retention policies shall include the process, timeframes, and documentation required for reporting the recovery of all overpayments.
 - b. CMS confirmed DHCF’s compliance with 42 C.F.R. 438.608(d) at page 9 of its FY 22 Focused Program Integrity Review of the D.C. Medicaid Program Report, available at <https://www.cms.gov/files/document/washington-dc-fy22-focused-pi-review-report.pdf>.
- d. Data Management Findings and Responses
 - i. Finding: DHCF's Reviews of Overpayments Provide Limited Completeness and Accuracy Assurance.
 - 1. DHCF Response: DHCF disagrees with this finding.
 - a. DC OIG states that “DHCF could not accurately determine whether MCOs reported all identified overpayments as required. Our audit found 14,445 overpayment transaction control numbers (TCNs) that were missing from encounter data, including 7,081 transactions from the FY 2023 Program Integrity Monthly Report (PIMR) and 7,364 transactions from the FY 2024 PIMR” and that “without reliable overpayment data, DHCF cannot effectively verify MCOs are identifying and recovering all overpayments.”
 - b. First, it is important to note that the PIMR is fundamentally not a “Financial Reconciliation Report.” The function of

the PIMR is to consolidate key program integrity activities to facilitate agency utilization review and investigatory priorities. Encounter data validation and reconciliation are conducted on an ongoing basis by the agency through multiple other functions and the PIMR report neither guides, nor is intended to supplant these activities. DHCF, along with its contracted Actuary, have extensively reviewed its data validation activities with the DC OIG.

- c. It is incorrect to state that 7,081 transaction control numbers (TCN) were missing from the FY 23 PIMR, and 7,364 TCNs were missing from the FY 24 PIMR. DHCF showed the DC OIG, in real time, all of the “missing” TCNs. The PIMR is a *retrospective* review, so the TCNs reviewed are for a *historical* period, and will not, by definition, align with *present* encounter data. The PIMR did not “fail” to include applicable TCNs. OIG initially presented DHCF with more than 11,000 TCNs it claimed were missing based on the FY2023 PIMRs. DHCF reviewed and identified all TCNs as being pulled directly from its own MMIS, so it is impossible for those claims to be missing from MMIS. DHCF met with the OIG and presented this data to the OIG, as well as sending OIG data files with all the TCNs showing that they were all present and accounted for in MMIS. DHCF has not been presented with the 7,364 TCNs allegedly missing from the FY24 PIMRs, but DHCF suspects that all those TCNs are from time periods outside of FY23, in which case they will not be found in the FY2023 claims data set that the OIG is running them up against. But they will still be found in MMIS because they come from MMIS.
- ii. Finding: DHCF Has Opportunities to Strengthen its Monitoring and Oversight of MCO Overpayment Reporting
 - 1. DHCF Response: DHCF disagrees with this finding.
 - a. The DC OIG characterized the following as “inaccuracies” in MCO overpayment reporting that “limit DHCF’s ability to effectively monitor these payments,” which inflates the impact of largely immaterial data:
 - i. One MCO PIMR had TCNs with file formatting that changed the last two digits to 00;
 - 1. DHCF Response: This was a one-time formatting error, whereby Excel “autocorrected” the TCNs to end in 00. Microsoft Excel has a formatting error that occasionally converts all digits greater than 15 to 15 digits, with the remaining digits being replaced by zeroes. The 17 digit TCN

number's last 2 digits were therefore converted to zeroes despite the MCO having uploaded the full TCN correctly. Once this issue was identified, DHCF worked with the MCO to timely update the data with the full TCN numbers. This is not a systemic issue.

- ii. Another MCO classified all overpayment recoveries as "Waste" and not "Fraud or Abuse;"

- 1. DHCF Response: This is immaterial for two reasons:

- a. First, the MCOs do not make the findings of "fraud" or "abuse." Findings of fraud and abuse is determined via a separate process by the Medicaid Fraud Control Unit (MFCU), following a preliminary investigation by DHCF.
 - b. Second, in the period reviewed by DC OIG, DHCF considers all of the identified overpayments properly categorized as "waste." The draft OIG Report does not identify any specific overpayment recoveries that it believes are nonetheless misclassified, so DHCF is unable to provide a further substantive response to the alleged errors.

- iii. There were instances where (PIMR) TCNs had dates outside of FY23.

- 1. DHCF Response: Since DHCF Program Integrity division (DPI) audit activities are retrospective, there will always be TCNs in the PIMR that are outside of the present fiscal year. This is by design.

- e. Program Integrity Findings and DHCF Responses

- a. Finding: DHCF Can Strengthen its Fraud Referral Processes to the MFCU. The DC OG states that "DHCF lacks a structured framework to consistently refer suspected fraud cases to the MFCU. This directly affects the District's ability to control Medicaid costs. For instance, when potential fraud cases are misclassified as "waste" or not properly escalated for investigation, the District may miss opportunities to find and address systematic fraud schemes. Misidentifying fraud could result in improper payments that increase program costs and waste taxpayer dollars."

- 1. DHCF Response: DHCF disagrees with this finding.

- a. DHCF has a written fraud referral policy and procedure that is based on, and consistent with, federal regulatory requirements. *See* 42 C.F.R. Sec. 455.12 *et. seq.* This document has previously been provided to the OIG. DPI has an investigations branch that conducts preliminary

investigations, consistent with 42 C.F.R. Sec. 455.14, to determine if credible allegations of fraud exist, and the payment suspension committee then convenes, consistent with our written policy and federal regulations, to determine if referral to law enforcement is justified under 42 C.F.R. Sec. 455.23. This framework is structured and effective.

- b. It is unclear from the DC OIG, how it suggests DHCF can improve its MCO fraud referral procedure. The fraud referral procedure is a stand-alone procedure, distinguished from other monitoring activities, such as overpayment review. The fraud referral procedure has been reviewed, in real time, with the MCOs during a dedicated meeting. The fraud referral procedure, which was provided to the DC OIG, includes: Potential Provider Fraud and Abuse Referral Document Form; Potential Provider Fraud and Abuse Referral Web Portal Form; Assignment of a referral number from DHCF. Upon receipt of a MCO fraud referral, DHCF initiates its regulatorily required “preliminary investigation” to determine the credibility of the referral. If credible, then DHCF refers the matter to the MFCU. In addition, this finding fails to acknowledge activities undertaken by DHCF since FY2023 that are directly relevant to this finding. For example, OIG was informed of comprehensive trainings conducted by DHCF with each of the MCOs individually in FY24 that focused on properly classifying investigations as fraud/waste/abuse, instructed the MCOs on how to improve their internal investigations to identify additional fraud, and have resulted in significantly higher fraud referrals during this current FY. It is unclear to DHCF whether the activities taken since the review period OIG examined are sufficient to address OIG's concerns or, if they are not, how it failed to address those concerns.
2. The DC OIG’s reference to the total number of fraud referrals in FY 23 is also incorrect, stating that “DHCF made 145 [fraud] referrals from sources other than MCOs, suggesting a significant disparity in how potential fraud is identified and escalated between MCO and non-MCO sources. This is incorrect, in FY 23 DHCF initiated 31 preliminary investigations, and referred 7 credible allegations of fraud to the MFCU. The “145” fraud referrals cited by the DC OIG is incorrect. In FY23, DHCF-DPI had 131 open investigations, inclusive of cases that had been opened in prior years and had not been closed due to ongoing activities, ongoing law enforcement investigations, or other reasons. Of those 131 cases, 7 cases were referred to the MFCU after DHCF determined

that, pursuant to 42 C.F.R. section 455.23, credible allegations of fraud existed. None of those cases were MCO initiated investigations.

3. Regarding the alleged misclassification of waste, crucially, the OIG has not presented any evidence of improper classifications by the MCOs beyond the fact that one MCO classified all items on the PIMR as waste. Waste is a distinct and valid classification. Absent evidence that the classifications at issue were improper, DHCF cannot agree with the claim that misclassifications were made.
 4. Lastly, all managed care network providers are required by federal law to be concurrently enrolled with the State Medicaid Agency. This means that every single managed care network provider, is also enrolled with DHCF. When DHCF develops its investigatory strategic plan, all enrolled providers are subject to review- managed care network providers are not excluded. DHCF determines its investigative priorities based on consideration of several factors, including but not limited to, aberrant utilization trends, or provider types/categories of services federally identified as high risk. Managed care network providers are absolutely not without oversight from DHCF- they are subject to, and not excluded from the scope of fraud investigations.
- ii. Finding : DHCF's Monitoring was Ineffective in Preventing Beneficiaries from Simultaneous Enrollment in Both Medicaid and Alliance Programs
1. DHCF Response: DHCF disagrees with this finding.
 2. It is unclear the sample, methodology, or data fields that were used by the DC OIG to conclude that "18/60" individuals had dual enrollment in the Alliance and Medicaid enrollment for periods ranging from two to twelve months. As was explained at length to the DC OIG, material to determining impermissible dual program enrollment, is to verify whether there are any "voided spans" during the subject enrollment period. Periods of apparent "dual enrollment, should be verified by checking if there is a corresponding "void span" in the District's Medicaid management Information System (MMIS), that retroactively voids enrollment in one of the two subject programs due to dispositive information received subsequent to initial enrollment. For example, if an individual is enrolled in the Alliance Program from July 2023-September 2024, and at any time during this enrollment period, DHCF receives citizenship information that qualifies them for Medicaid, then the eligibility and enrollment system sends an automatic update to the claims processing system that "voids" the entirety of the Alliance span, and replaces it with a Medicaid span for the subject period. During DHCF's multiple meetings with the DC OIG, it repeatedly explained that the "voided span" data field must be considered in order to validate any conclusion of duplicate enrollment. It does not appear that the DC OIG reviewed the

“voided span” data at all. In the absence of this information, it is inaccurate to conclude that an individual had duplicate enrollment.

- f. Health Care Access and Service Delivery Findings and DHCF Responses
 - i. Finding: Inadequate DHCF Oversight of Prior Authorization Could Impact Beneficiary Health Care Access
 - 1. DHCF Response: DHCF disagrees with the methodology underlying this finding. The DC OIG’s calculations are incorrect. DHCF agrees to develop a process to review a representative sample of managed care prior authorization denials and appeals, on a periodic basis.
 - 2. DC OIG states that in FY23, there were 19,327 denials out of 38,958 requests. However, of the 19,327 “denials,” 12,674 were for services categorically not covered under the D.C. State Plan for Medicaid. There is no basis to request a prior authorization for a non-covered service. Prior authorizations are only available for denied covered services. Further, 288 “denials” were either subsequently approved, or the request was withdrawn. Therefore, the 12,674 requests for non-covered services, and 288 approved or withdrawn requests should also be excluded from the total “denials.” Properly excluding these cases 12,962 cases, yields a denial of 6,365 out of 38,958 requests, or a 16% denial rate, rather than the incorrect 50% rate asserted in the Draft Audit Report.
 - 3. DHCF agrees to strengthen its health care access oversight by implementing a process to review, on a periodic basis, a representative sample of denied and appealed cases to identify potential, data supported access barriers for covered services. Estimated Completion Date: March 1, 2026.
- g. Contract Administration
 - i. Finding: DHCF Contract Administrators Did Not Complete Certification Requirements
 - 1. DHCF Response: DHCF disagrees with this finding.
 - a. The subject Contract Administrators were previously certified and were unable to complete recertification requirements only due to lack of availability of OCP training for recertification. DHCF was unable to comply during the period of review due to reasons outside of its purview.
 - b. The D.C. Office of Contracts and Procurement (OCP) exclusively administers Contract Administrator (CA) training for applicable District employees. OCP did not make the applicable CA training available for District employees, during the period of review, which precluded timely completion of recertification.
 - c. Once the training became available, all CAs promptly enrolled and have since completed their recertification.

- ii. Finding: DHCF Did Not Conduct Site Visits in its Readiness Assessments of MCOs.
 - 1. DHCF Response: DHCF disagrees with this finding.
 - a. All readiness reviews were completed within required timeframes and in accordance with 42 CFR § 438.66 (1)(2)(3)(4).
 - b. During the specific period of review in this audit, only 1 MCO, Amerigroup, which was newly procured and absent from the program for 3 years, required a readiness review.
 - c. Amerigroup's readiness review was completed in accordance with 42 CFR § 438.66 (1)(2)(3)(4). HSCSN, AmeriHealth, and MedStar were not subject to additional mandatory readiness reviews, as they were not newly contracted MCOs. The reviews had been completed prior to the period of review at issue in the audit.

AUDIT REPORT

Medicaid Eligibility Determinations Audit

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

OIG No. 24-1-04JA

June 18, 2025



DRAFT

DANIEL W. LUCAS
INSPECTOR GENERAL



OUR MISSION

We independently audit, inspect, and investigate matters pertaining to the District of Columbia government in order to:

- prevent and detect corruption, mismanagement, waste, fraud, and abuse;
- promote economy, efficiency, effectiveness, and accountability;
- inform stakeholders about issues relating to District programs and operations; and
- recommend and track the implementation of corrective actions.

OUR VISION

We strive to be a world-class Office of the Inspector General that is customer focused and sets the standard for oversight excellence!

OUR VALUES

Accountability: We recognize that our duty extends beyond oversight; it encompasses responsibility. By holding ourselves accountable, we ensure that every action we take contributes to the greater good of the District.

Continuous Improvement: We view challenges not as obstacles, but as opportunities for growth. Our commitment to continuous improvement drives us to evolve, adapt, and enhance our practices.

Excellence: Mediocrity has no place in our lexicon. We strive for excellence in every facet of our work.

Integrity: Our integrity is non-negotiable. We act with honesty, transparency, and unwavering ethics. Upholding the public's trust demands nothing less.

Professionalism: As stewards of oversight, we maintain the utmost professionalism. Our interactions, decisions, and conduct exemplify the dignity of our role.

Transparency: Sunlight is our ally. Transparency illuminates our processes, decisions, and outcomes. By sharing information openly, we empower stakeholders, promote understanding, and reinforce our commitment to accountability.





DISTRICT OF COLUMBIA | OFFICE OF THE INSPECTOR GENERAL

MEMORANDUM

To: Wayne Turnage, M.P.A.
Deputy Mayor for Health and Human Services and
Director, Department of Health Care Finance
441 4th Street NW, Suite 900 South
Washington, DC 20001

A D Rachel Pierre
Interim Director, Department of Human Services
64 New York Avenue NE, 6th Floor
Washington, DC 20002

From: Daniel W. Lucas
Inspector General

A handwritten signature in blue ink, appearing to read "DW Lucas", is written over the printed name and title of the Inspector General.

Date: June 18, 2025

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

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

This draft report includes eight recommendations. Please review our draft report and provide us your feedback. In your feedback, indicate whether you agree or disagree with each recommendation. For each recommendation, your response should include actions taken or planned, target dates for completion of planned actions, and reasons for any disagreement with the findings or recommendations. Your response may propose alternative solutions that will address the intent of the recommendations more effectively or efficiently. You must provide us your written feedback no later than July 9, 2025. A copy of your response will be included in our final report.

We intentionally limit the distribution of our draft audit reports. Therefore, please share this draft report only with those directly involved in preparing your response.

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



EXECUTIVE SUMMARY

Medicaid Eligibility Determinations Audit

Summary

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

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

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

Objectives

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

Findings

Through this audit, we made the following findings:

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

Recommendations

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

Management Response

[Pending receipt of management response]



Medicaid Eligibility Determinations Audit

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INTRODUCTION

Objectives

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

See Appendix 3 for our audit scope and methodology.

Background

Medicaid Program Overview

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

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

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

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

¹ <https://www.fac.gov/assets/compliance/2024-Compliance-Supplement.pdf>

² Per [Social Security Act § 1902\(e\)\(53\)\(F\)\(v\)\(II\)](#), "The term 'State' means 1 of the 50 States or the District of Columbia."

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

Continuous Coverage Requirements

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

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

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

Unwinding Process Requirements

In March 2022, the Centers for Medicare and Medicaid Services (CMS) issued State Health Official Letter No. 22-001, announcing that states must initiate eligibility renewals for all individuals enrolled in Medicaid within 12 months of the start of the

³ Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020).

⁴ Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, 136 Stat. 4459 (2022).

state's unwinding period.⁵ Furthermore, states were required to complete these renewals within 14 months of the unwinding period's commencement.

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

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

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

District Of Columbia's Medicaid Unwinding Efforts

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

By March 2024, the District started all Medicaid renewals and reached an 80 percent renewal rate.⁸ The District's 80 percent renewal rate demonstrated significant

⁵ Letter from Daniel Tsai, Acting Deputy Administrator and Director, Department of Health & Human Services, Centers for Medicare & Medicaid Services to State Health Official, Executive Summary (SHO# 22-001) (Mar. 3, 2022) (on file with the OIG).

⁶ Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, 136 Stat. 4459 (2022).

⁷ Department of Health Care Finance, "Restarting Medicaid Renewals: The End of the Continuous Enrollment Requirement Bi-weekly Meeting #28 Medicaid Renewal Community Meeting" (PowerPoint presentation, Washington, DC, May 22, 2024), https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Medicaid%20Renewal%20Community%20Meeting%20052224.pdf.

⁸ Department of Health Care Finance, "Restarting Medicaid Renewals," slide 4.

progress in returning to normal eligibility operations while ensuring eligible individuals maintained coverage.

AUDIT RESULTS

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

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

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

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

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

In response, DHCF released its *Operational Plan for Unwinding Continuous Coverage and the COVID-19 Public Health Emergency* (Unwinding Plan) in March

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

2023.¹⁰ The Unwinding Plan established clear objectives and internal control activities to align with federal requirements to mitigate risks associated with the return to routine operations.

Key strengths of the DHCF's Unwinding Plan include:

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

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

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

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

¹⁰ Operational Plan for Unwinding Continuous Coverage and the COVID-19 Public Health Emergency.

¹¹ *Supra* note 6.

¹² *Supra* note 3.

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

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

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

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

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

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

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

¹³ [29 DCMR § 9501.31](#).

¹⁴ 29 DCMR § 9501.32.

¹⁵ To understand our sampling methodology, please refer to Appendix 3.

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

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

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

Finding 4: DHS Did Not Always Maintain Required Supporting Documentation

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

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

The failure to keep proper documentation undermines confidence in DHS' ability to ensure accurate eligibility determinations and program integrity. Moreover,

¹⁶ [42 CFR § 431.17](#)(b)(1)(i).

¹⁷ [42 CFR § 431.17](#)(c)(1).

¹⁸ GOV'T OF THE DISTRICT OF COLUMBIA, DEP'T OF HUMAN SERVICES, ESA POLICY MANUAL, PART 8, CHAPTER 1 (undated).

inadequate documentation retention can hinder oversight, audits, and corrective actions needed to address potential compliance issues.

Recommendation 3 (DHS)

We recommend that the DHS Director:

Review its record retention policies and procedures to ensure alignment with ESA's program policy manual and applicable federal requirements (42 CFR § 431.17).

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

To ensure transparency, accountability, and fairness, federal and District regulations require notifying applicants when Medicaid applications are denied. Title 29 DCMR § 9508.1 mandates that individuals applying for Medicaid through DHS be informed of their right to a fair hearing when their Medicaid application is denied.¹⁹ Additionally, 29 DCMR § 9501.32 requires DHS to promptly provide ineligible Medicaid applicants with information about potential eligibility for other IAPs, along with details about their right to appeal the determination.²⁰

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

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

¹⁹ 29 DCMR § 9508.

²⁰ 29 DCMR § 9501.32.

supervisory internal controls to verify that required notices are sent with proper explanations, applicants may be unable to mount effective appeals of potentially erroneous decisions.

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

Recommendation 4 (DHS)

We recommend that the DHS Director:

Develop and implement a procedure to ensure adequate supervisory review of Medicaid applications when Medicaid applicants are determined ineligible.

Recommendation 5 (DHS)

We recommend that the DHS Director:

Establish a formal mechanism to ensure the DCAS timely and accurately reflects eligibility determinations when Medicaid applicants are determined ineligible.

Recommendation 6 (DHS)

We recommend that the DHS Director:

Develop and implement procedures to ensure case workers add case narratives in DCAS to accurately explain why Medicaid applicants are determined ineligible.

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

Federal standards require information systems to keep accurate and reliable data. According to GAO's [Standards for Internal Control in the Federal Government](#) (GAO Green Book), management must design information systems and internal controls that ensure data completeness, accuracy, and validity. These standards help

agencies achieve operational effectiveness, carry out objectives, and respond to risks.²¹

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

The underlying causes of these deficiencies include:

- DHS did not have clear procedures or effective oversight to ensure timely and accurate updates to DCAS, including missing automated checks to spot inconsistencies, inefficient workflows for processing updates, and limited system tools to flag issues, leading to delays and errors.
- DHS policies and procedures lack effective internal controls to detect errors in manual updates within the eligibility system, including inadequate monitoring processes to identify and address mistakes promptly.

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

Recommendation 7 (DHCF)
We recommend that the DHCF Director: Develop and implement effective internal control procedures for systematic monitoring of manual updates in DCAS.

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

Recommendation 8 (DHCF)

We recommend that the DHCF Director:

Update policies and procedures to define specific internal controls for prompt detection and remediation of errors in manual processes.

CONCLUSION

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

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

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



APPENDIX 1. FINDINGS

Table of Findings

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



APPENDIX 2. RECOMMENDATIONS

Table of Recommendations

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



APPENDIX 3. SCOPE & METHODOLOGY

Scope

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

Methodology

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

Document Review

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

Interviews and Site Visits

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

System Access and Data Reliability Assessment

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

Sample Testing and Analysis

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

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

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

Sampling Design and Selection

Sampling Frame

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

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

Table 1. Breakdown of Sample Strata

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

Sample Unit

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

Sample Design

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

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

Sample Size

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

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

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

The allocation of samples was as follows:

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

Method for Selecting Samples:

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



APPENDIX 4. DHS MANAGEMENT RESPONSE

DHS management's response will be included in this section.



APPENDIX 5. DHCF MANAGEMENT RESPONSE

DHCF management's response will be included in this section.

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



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

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

Date: July 16, 2025

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

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

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

In 7 out of 47 cases, the DC OIG found that the DCAS System incorrectly referred to ineligible cases as "Active." The DC OIG recommends that the DHCF Director develop and implement effective internal control procedures for systematic monitoring of manual updates in DCAS. DHCF disagrees that DCAS "did not consistently reflect correct or accurate eligibility status." Eligibility was determined correctly for the subject beneficiaries; the cases remained in "active" status because the automatic process to close cases was paused during the COVID-19 Public Health Emergency, to comply with the continuous enrollment mandate. Notwithstanding, as part of the Commanding Case Closure Initiative, DHCF and DHS will provide refresher training to staff on the appropriate procedures proper case closure, and will incorporate a check for cases with an active status but no eligibility in the supervisory review process.

Estimated Completion Date: End of Fiscal Year 2026

AUDIT REPORT

Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations

OIG No. 23-1-07HT

July 10, 2025



DRAFT

DANIEL W. LUCAS
INSPECTOR GENERAL



OUR MISSION

We independently audit, inspect, and investigate matters pertaining to the District of Columbia government in order to:

- prevent and detect corruption, mismanagement, waste, fraud, and abuse;
- promote economy, efficiency, effectiveness, and accountability; inform stakeholders about issues relating to District programs and operations; and
- recommend and track the implementation of corrective actions.

OUR VISION

We strive to be a world-class Office of the Inspector General that is customer focused and sets the standard for oversight excellence!

OUR VALUES

Accountability: We recognize that our duty extends beyond oversight; it encompasses responsibility. By holding ourselves accountable, we ensure that every action we take contributes to the greater good of the District.

Continuous Improvement: We view challenges not as obstacles, but as opportunities for growth. Our commitment to continuous improvement drives us to evolve, adapt, and enhance our practices.

Excellence: Mediocrity has no place in our lexicon. We strive for excellence in every facet of our work.

Integrity: Our integrity is non-negotiable. We act with honesty, transparency, and unwavering ethics. Upholding the public's trust demands nothing less.

Professionalism: As stewards of oversight, we maintain the utmost professionalism. Our interactions, decisions, and conduct exemplify the dignity of our role.

Transparency: Sunlight is our ally. Transparency illuminates our processes, decisions, and outcomes. By sharing information openly, we empower stakeholders, promote understanding, and reinforce our commitment to accountability.





DISTRICT OF COLUMBIA | OFFICE OF THE INSPECTOR GENERAL

MEMORANDUM

To: Wayne Turnage, M.P.A.
Deputy Mayor for Health and Human Services and
Director, Department of Health Care Finance

From: Daniel W. Lucas
Inspector General 

Date: July 10, 2025

Subject: **Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations | OIG No. 23-1-07HT**

This draft report presents our findings on the District's oversight of Medicaid Managed Care Organizations (MCOs). Our objectives were to determine whether the Managed Care health care delivery system: (1) reduced cost, and (2) increased access to health care services.

We found that while DHCF established oversight frameworks, implementation gaps could limit the agency's ability to ensure MCOs are reducing costs and improving access. Key issues include incomplete monitoring policies, inadequate overpayment controls, and limited review of MCO service denials that may have affected beneficiary care.

We have made 16 recommendations that could help DHCF strengthen its MCO oversight to better protect District funds and ensure residents receive appropriate health care services. If implemented, these changes can improve DHCF's ability to hold MCOs accountable and require them to meet all their contractual obligations to both the District and beneficiaries covered by their plans.

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

Please review this draft report and provide your response by July 25, 2025, indicating whether you agree or disagree with each recommendation and describe planned actions with target dates for implementation. If you propose alternative solutions, please explain how they will address the intent of our recommendations.

We appreciate the cooperation and courtesy extended to our staff during this audit. If you have any questions, please contact Dr. Slemo Warigon, Assistant Inspector General for Audits, at slemo.warigon@dc.gov or (202) 792-5684.



EXECUTIVE SUMMARY

Opportunities for Strengthening District Oversight of Medicaid Managed Care

Summary

In FY 2023, the District of Columbia (DC or the District) government signed three contracts valued at \$8.8B to provide healthcare services to approximately 261,000 low-income and disabled residents through Medicaid, using a Managed Care health care delivery system model. Under this system, the District pays private insurance companies called Managed Care Organizations (MCOs) a fixed monthly amount per beneficiary, and the MCOs coordinate care, manage provider networks, and ensure beneficiaries receive appropriate health services. The Department of Health Care Finance (DHCF) serves as the District's Medicaid agency and is responsible for overseeing these MCO contracts.

The Office of the Inspector General (OIG) identified this audit through its risk assessment process due to the significant impact Medicaid program reforms and MCO contracts have on District operations and the wellbeing of District residents.

Objectives

The objectives of this audit engagement were to determine whether DHCF's oversight of the Managed Care health care delivery system:

1. reduced cost, and
2. increased access to health care services.

The scope of this audit was for fiscal year (FY) 2023.

Findings

Our audit identified both strengths and opportunities for improvement in DHCF's oversight of Medicaid MCOs.

DHCF established frameworks for quality assessment, monitoring, and oversight. However, the following significant implementation gaps affect both cost and health care access:

- Incomplete monitoring policies and inadequate overpayment controls limited DHCF's ability to ensure cost efficiency.
- Data integrity issues prevented verification of MCO-reported overpayments and health services encounters.
- DHCF did not review prior authorization denials despite MCOs denying 50% of requests, potentially limiting beneficiary access to care.
- Contract administrators lacked required training.
- DHCF did not conduct the required MCO readiness assessments.

Recommendations

Our 16 recommendations address these gaps with specific actions to strengthen oversight and improve DHCF's ability to ensure the Managed Care system achieves its goals of reducing costs and increasing healthcare access.

Management Response

[Pending receipt of DHCF management response, which will be placed in its entirety in Appendix 3.]

Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations

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INTRODUCTION

Understanding Medicaid in the District

Medicaid is a joint federal-state health insurance program that provides essential health care services to eligible low-income and disabled residents.¹ For District residents who qualify, Medicaid covers a wide range of services including doctor visits, hospital care, prescription medications, mental health services, and transportation at little or no cost.

The Department of Health Care Finance (DHCF) serves as the District's Medicaid agency.² Its mission is to improve health outcomes by providing access to comprehensive, cost-effective, and quality healthcare services for residents of the District of Columbia.

What is the Managed Care Health Care Delivery System?

Since 1998, the District has used a Managed Care approach to deliver Medicaid services. Under this system:

1. The District contracts with private insurance companies called MCOs.
2. The District pays these MCOs a fixed amount per beneficiary per month (known as a "capitation payment").
3. MCOs have networks of healthcare providers who serve beneficiaries.
4. MCOs are responsible for coordinating care, processing claims, and ensuring beneficiaries receive appropriate services.³

The intent of the Managed Care system is to better control costs while improving care coordination. According to DHCF data, approximately 261,000 District residents were enrolled in Managed Care programs by FY 2023.⁴ The District contracted with three MCOs during our audit period to provide these services.⁵

¹ Title XIX of the Social Security Act established Medicaid. The program is governed by 42 USC § 1396 et seq.

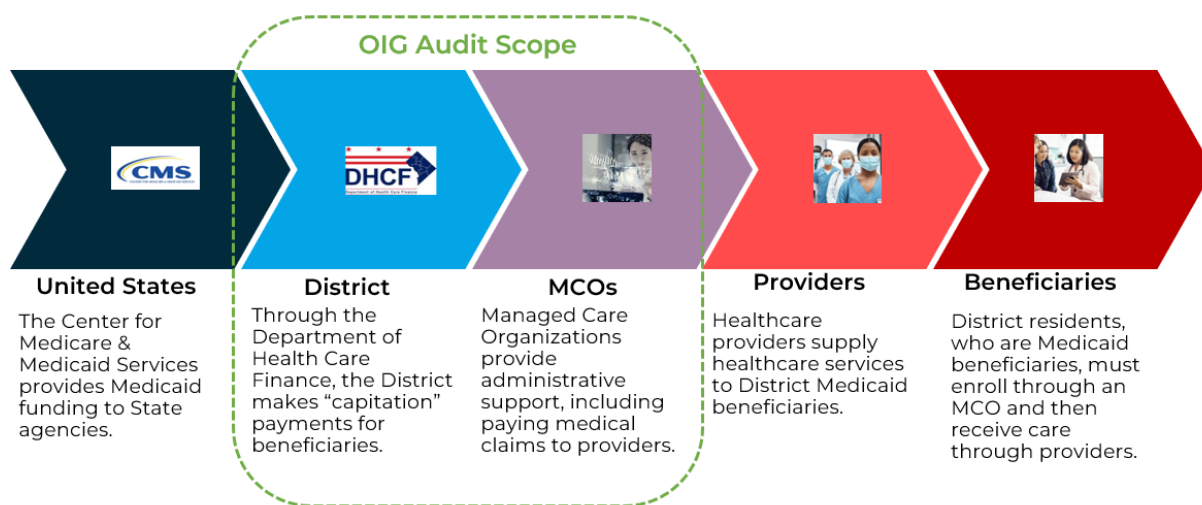
² DC Code § 7-771.03 establishes DHCF's purpose and responsibilities as the District's Medicaid agency.

³ The District received authority to operate a Medicaid Managed Care program in 1998 through a waiver approved by the Centers for Medicare and Medicaid Services (CMS).

⁴ DC Department of Health Care Finance, Monthly Enrollment Report – FY 2023, <https://dhcf.dc.gov/node/1758206> (last visited June 16, 2025).

⁵ See DHCF Contract Numbers CW99927, CW99929, and CW99931 for Medicaid Managed Care services, FY 2023.

Figure 1. The District's Medicaid Managed Care System



Why This Audit Matters

DHCF is required to provide oversight of the MCOs to ensure they comply with federal and District laws, regulations, contracts, and policies.⁶ Effective oversight is essential because:

- The District spends significant public funds on these contracts, totaling \$8.8B over five years, with the option to extend the period of performance by another five years;
- MCOs must support adequate provider networks to ensure access to care;
- Beneficiaries depend on these services for their health care needs; and
- Program integrity activities help prevent and identify fraud, waste, and abuse.

Our audit examined whether the District's internal controls over the Managed Care system can better ensure its goals of reducing costs and improving access to health care services for District residents.

⁶Title 42 CFR § 438.66 requires state Medicaid agencies to implement a monitoring system for all Managed Care programs.

AUDIT METHODOLOGY

How We Conducted This Audit

Our audit focused on DHCF's oversight of the three MCOs that provided Managed Care services to District residents during FY 2023. We designed our approach to evaluate the agency's oversight as related to the following questions:

1. Has DHCF's oversight of the MCOs impacted costs?
2. Has DHCF's oversight of the MCOs increased access to health care services?

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

Risk-Based Auditing Approach

We began with a formal risk assessment to identify the highest-risk areas that might affect costs and access to care. This assessment led us to focus on six key areas:

- Oversight and contract compliance;
- Overpayments to providers;
- Enrollment processes;
- Data tracking of health services (encounters);
- Service use or utilization; and
- Payment rates to MCOs.

What We Reviewed

To thoroughly evaluate DHCF's oversight of the MCOs, our audit team:

- Examined federal and District laws and regulations that govern Medicaid Managed Care, such as the CFR, DCMR, and DC Code;⁷

⁷ Key federal regulations governing Medicaid Managed Care include 42 CFR Part 438. District regulations are found in DCMR Title 29.

- Reviewed DHCF policies and procedures, annual technical reports, external quality reviews, contract administrator delegation letters, and other documents;
- Reviewed DHCF's contracts and contract modifications with the three MCOs and related vendors in the Managed Care system;
- Analyzed reports and attestation forms that the MCOs submitted to DHCF;
- Interviewed key personnel from multiple DHCF divisions and other District agencies to complete process walkthroughs and interviews;
- Analyzed data from FY 2023 on enrollment, health care services provided to beneficiaries, and overpayments;
- Identified 60 potential instances of duplicate enrollment and performed a 100% examination of these cases using the DC OMNICAID platform to verify whether beneficiaries were abnormally enrolled in more than one program;
- Examined how DHCF identifies, monitors, and recovers overpayments;
- Reviewed DHCF's processes for ensuring MCOs maintain adequate provider networks; and
- Assessed prior authorization requests and appeals.

Audit Framework

We used the U.S. Government Accountability Office's (GAO) "Standards for Internal Control in the Federal Government" (the Green Book) as our evaluation framework.⁸ This framework helped us assess whether DHCF had effective systems in place to:

- Ensure MCOs meet their contractual obligations
- Monitor the quality of care provided to beneficiaries
- Identify and prevent fraud, waste, and abuse
- Maintain program integrity

Scope and Limitations

Our audit covered the FY 2023 operations of the Managed Care system. We recognized that during this period, DHCF was managing the final months of the federal COVID-19 Public

⁸ Standards for Internal Control in the Federal Government, GAO-14-704G (September 2014), also known as the 'Green Book,' provides a framework for establishing and maintaining effective internal control. See <https://www.gao.gov/products/GAO-14-704G> (last visited June 16, 2025).

Health Emergency, which created unique challenges.⁹ Our findings and recommendations acknowledge these challenges while identifying opportunities for improvement.

It is important to note that our audit did not question the District's decision to use the Managed Care approach. Instead, we focused on how DHCF implemented and monitored this approach with oversight over the MCOs. Without internal controls, the District risked not being able to ensure effective Managed Care program operations, the protection of beneficiary interests, and the safeguarding of District funds.

KEY FINDINGS AND RECOMMENDATIONS

Our audit of DHCF's oversight of the Medicaid Managed Care health care system revealed both strengths and opportunities for improvement. We organized our findings into five categories to help readers understand how they relate to the audit objectives of cost reduction and improved access to health care.

The first three findings highlight effective frameworks DHCF has established, which serve as a foundation for program oversight. The later findings identify specific areas where strengthening internal controls and oversight mechanisms would better ensure that the Managed Care system effectively reduces costs and improves access to health care for District residents.

For each finding, we provide specific recommendations to DHCF for addressing the identified issues. Implementation of these recommendations would help the District maximize the benefits of the Managed Care approach while safeguarding public funds and improving health outcomes for beneficiaries.

Development of Systems and Frameworks

Finding 1 – DHCF Developed a Framework to Assess Quality and Appropriateness of Care for the MCOs

The applicable federal regulation, 42 CFR § 438.340, requires state Medicaid agencies to develop a quality strategy to assess care provided by MCOs. DHCF met this requirement by developing its Medicaid Managed Care Quality Strategy framework, which includes mechanisms for contract management, data collection, performance improvement projects, and quality assessment.¹⁰ DHCF developed this framework to respond to federal requirements and ensure MCOs deliver quality care to beneficiaries. This framework allows DHCF to monitor MCO performance, hold them accountable to standards, and

⁹ The federal Public Health Emergency ended on May 11, 2023. The District's Public Health Emergency ended on July 25, 2021, per Mayor's Order 2021-096, § 11.

¹⁰ DHCF, Medicaid Managed Care Quality Strategy: January 30, 2020
https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/DC%20Medicaid%20Managed%20Care%20Quality%20Strategy%202020.pdf.

improve the quality of care for Medicaid beneficiaries, supporting the audit objective of increased access to health care services.

Finding 2 – DHCF Developed a Monitoring and Compliance Framework for the MCOs

Federal regulations (42 CFR §§ 438.66 and 438.3) require state Medicaid agencies to implement procedures for regular oversight, monitoring, and evaluation of MCO performance. DHCF established a monitoring and compliance framework within its Medicaid Managed Care Quality Strategy. This framework requires MCOs to submit comprehensive reports covering case management, performance improvement projects, financial status, quality outcomes, and provider network accessibility. DHCF implemented this framework to fulfill regulatory requirements and strengthen MCO accountability.

The monitoring framework enables DHCF to systematically track MCO performance, identify compliance issues, and address them during bi-monthly operational meetings with MCOs led by its Division of Program Integrity. This supports both audit objectives by helping control costs and ensure beneficiaries have appropriate access to services.

Finding 3 – DHCF Had a System of Oversight for the Managed Care Health Care System

DHCF created a structured oversight system with distinct divisions responsible for different aspects of Medicaid Managed Care:

- The Health Care Delivery and Management Administration (HCDMA) oversees MCO contracts and supports other activities related to health care delivery;
- The Division of Program Integrity monitors MCO activities to identify and prevent fraud, waste, and abuse;
- The Division of Analytics and Policy Research evaluates health care delivery systems using data, research, and analysis; and
- The Health Care Operations Administration manages claims payment and administrative contracts along with the District's Medicaid Management Information System (MMIS)

DHCF designed this structure to establish clear lines of authority and responsibility for Managed Care oversight. By maintaining divisions with specific roles and responsibilities, DHCF created an organizational foundation for oversight of the Medicaid Managed Care program. This aligns with the Green Book's emphasis on management's role in establishing an effective

internal control environment to mitigate risks, maintain lines of communication, and monitor results to remediate deficiencies.¹¹

Oversight and Accountability

While DHCF established several foundational frameworks, our audit identified specific areas where oversight and accountability mechanisms need strengthening. The following findings highlight gaps in policies, procedures, and contract language that affect DHCF's ability to effectively monitor MCOs and hold them accountable. Addressing these issues would improve the District's ability to control costs and ensure appropriate access to care for Medicaid beneficiaries.

Finding 4 – Not All DHCF Division Policies and Procedures for Monitoring MCOs Were Complete

DC Code § 7-771.03(3) requires DHCF to “develop eligibility, service coverage, and service delivery and reimbursement policies for the District’s health-care-financing programs that ensure improved access and efficient delivery of service.” The Green Book emphasizes that management must communicate policies and procedures so personnel can implement control activities for their assigned responsibilities effectively.¹²

DHCF's HCDMA division lacked complete policies and procedures for monitoring MCO compliance during FY 2023. Specifically, its policies did not include guidance on using dashboards, tools, and other resources needed to verify MCO compliance.

The division relied heavily on contracts and reports rather than comprehensive monitoring policies. HCDMA officials acknowledged that a review of their policies found that many were incomplete because they duplicated contract language without explaining how to use oversight tools.

Without complete, documented procedures, HCDMA staff lacked clear guidance on how to monitor MCOs effectively. While the division pointed to compensating controls (program monitors and quarterly meetings), these do not provide the same level of assurance as documented procedures. This gap in internal controls may have limited HCDMA's ability to ensure MCOs were reducing costs and providing adequate access to care for beneficiaries.

Incomplete monitoring procedures may have limited HCDMA's ability to identify instances where MCOs were not controlling costs effectively or to take timely corrective action. Without standardized monitoring procedures, HCDMA

¹¹ [GAO Green Book § 1.05.](#)

¹² [GAO Green Book § 12.04.](#)

could not consistently verify that MCOs responded appropriately to beneficiaries' health care needs.

Recommendation 1

We recommend that the Director, DHCF:

Develop and implement comprehensive policies and procedures for all divisions that monitor MCOs, including detailed guidance on using oversight dashboards and monitoring tools to effectively assess cost reduction and health care access.

Finding 5 – MCO Contracts Contained Incomplete Overpayment Recovery and Retention Policies

Federal regulations require MCO contracts to address overpayment retention policies—governing whether the MCO that identified and recovered the overpayment gets to keep some or all of those funds or must return them to DHCF.¹³

In FY 2023, the District's MCO contracts did not include the detailed overpayment retention policy language mandated by 42 CFR § 438.608(d)(1)(iii). While DHCF had an unwritten "finder's keepers" arrangement with the MCOs (allowing them to keep overpayments they found through their own efforts), the agency did not formalize this arrangement in the contracts as required by federal regulations.

Further, DHCF operated under this informal arrangement rather than setting up formal contractual language despite a July 2017 federal implementation deadline. Although the District created contract modifications in FY 2024, the language is still incomplete and does not meet federal requirements specifying timeframes and documentation for payment of overpayment recoveries to the District in situations where MCO retention is not permitted.

The missing contractual language relates to our cost savings audit objectives. Without clear recovery and retention provisions, the District lacked contractual authority to hold MCOs accountable for properly handling overpayments. This potentially allowed MCOs to keep funds that should have been returned to the District.

¹³ 42 CFR § 438.608(d)(1)(iii) requires contracts to specify "processes, timeframes, and documentation required for payment of recoveries of overpayments [to the state agency] where the MCO... is not permitted to retain some or all of the recoveries of overpayments."

Recommendation 2

We recommend that the Director, DHCF:

Modify the MCO contracts to specify the timeframes and documentation required for payment of overpayment recoveries to the District in situations where MCO retention is not permitted and establish procedures for refunding the federal share of these overpayments to CMS as required by federal regulations.

Data Management and Reporting

Effective oversight of MCOs requires robust data management systems and accurate reporting mechanisms. Our audit identified several issues with how DHCF collects, verifies, and uses data from MCOs, particularly related to overpayment reporting. These findings directly impact the District's ability to control costs and ensure that resources are available to support healthcare access for beneficiaries.

Finding 6 – DHCF's Reviews of Overpayments Provide Limited Completeness and Accuracy Assurance

Federal regulation 42 CFR § 438.608(a)(2) requires MCOs, through their contracts with the State, to report all overpayments identified or recovered to the state Medicaid agency. The Green Book emphasizes that management should use quality data and information from reliable sources to make informed decisions and evaluate performance.¹⁴

DHCF could not accurately determine whether MCOs reported all identified overpayments as required. Our audit found 14,445 overpayment transaction control numbers (TCNs) that were missing from encounter data, including 7,081 transactions from the FY 2023 Program Integrity Monthly Report (PIMR) and 7,364 transactions from the FY 2024 PIMR.¹⁵

DHCF relied primarily on MCOs' monthly attestations certifying the completeness and accuracy of the data provided, rather than implementing robust verification processes. The agency's standard operating procedures did not include sufficient mechanisms to compare reported overpayments for completeness and accuracy.

These data validation weaknesses relate to both of our audit objectives. Without reliable overpayment data, DHCF cannot effectively verify whether MCOs are identifying and recovering all overpayments, potentially allowing

¹⁴ [GAO Green Book § 13.04](#).

¹⁵ Reviewed documentation included the FY 2024 PIMR because it also contained FY 2023 transactions.

improper payments to go undetected and unrecovered. This may increase program costs and reduce funds available for beneficiary services.

DHCF officials acknowledged that the agency lacks the capability to independently confirm overpayment data, creating a risk that MCOs could be incentivized to underreport overpayments to keep funds.

Recommendation 3

We recommend that the Director, DHCF:

Implement a comprehensive data validation system that requires unique Transaction Control Numbers for all encounters across all systems, establishes clear standards for format and content, and ensures consistent tracking between encounter data and all reports to improve overpayment monitoring and cost recovery.

Recommendation 4

We recommend that the Director, DHCF:

Independently audit the accepted and paid encounter data submitted through the MCOs' monthly financial reconciliation reports.

Recommendation 5

We recommend that the Director, DHCF:

Establish a regular independent audit process for accepted and paid encounter data submitted through the MCOs' monthly financial reconciliation reports, rather than relying solely on attestations, to verify completeness, identify potential overpayments, and improve cost control.

Recommendation 6

We recommend that the Director, DHCF:

Ensure MCOs receive uniform training and feedback about how to complete the PIMR data before submission to DHCF.

Finding 7 – DHCF Has Opportunities to Strengthen its Monitoring and Oversight of MCO Overpayment Reporting

Federal regulation 42 CFR § 438.608(a)(2) requires MCOs, through its contract with the State, to report all overpayments identified or recovered to the state Medicaid agency. Additionally, MCO contracts require them to report overpayments and specify whether they are due to fraud, waste, or abuse. The Green Book states that management should use quality information that is appropriate, current, complete, accurate, accessible, and provided on a timely basis.¹⁶

Our audit found several inaccuracies in MCO overpayment reporting that limit DHCF's ability to effectively monitor these payments:

- One MCO's PIMRs had 1,870 transaction control numbers with file formatting that changed the last two digits to "00."
- Another MCO classified all overpayment recoveries as "waste" in FY 2023 without reporting any fraud or abuse.
- We found instances where TCNs had dates outside of FY 2023.

While DHCF developed the PIMR for MCOs to report overpayments and needed certification of data accuracy, the agency relied primarily on attestations rather than validation processes. DHCF did not have systematic procedures for auditing PIMR data quality or enforcing consistent reporting standards across all MCOs.

These data reporting inaccuracies relate to both of our audit objectives. Inconsistent overpayment classification and reporting could make it difficult for DHCF to identify potential fraud, waste, and abuse patterns that could be addressed to reduce costs. Without standardized reporting, the District may not be able to effectively track overpayment recovery performance across MCOs or identify opportunities for systemic improvements. Additionally, when overpayment issues are not properly classified or tracked, the District may overpay for managed care services. Furthermore, unaddressed fraud and abuse could lead to inappropriate service denials or access barriers for legitimate health care needs.

¹⁶ [GAO Green Book § 13.05](#).

Recommendation 7

We recommend that the Director, DHCF:

Establish regular data quality audits of Program Integrity Monthly Reports that address inconsistent Transaction Control Number formatting, standardize fraud/waste/abuse classifications, and implement corrective actions for non-compliant MCO reporting to improve overpayment tracking and recovery.

Program Integrity and Fraud Prevention

Effective program integrity measures are critical for controlling Medicaid costs and ensuring that limited resources are directed toward legitimate health care needs. Our audit identified opportunities for DHCF to strengthen its fraud detection, referral processes, and enrollment monitoring to better protect public funds.

Finding 8 – DHCF Can Strengthen Fraud Referral Processes to the MFCU

Federal regulation 42 CFR § 455.21(a)(1) requires state Medicaid agencies to refer all suspected provider fraud cases to their Medicaid Fraud Control Unit (MFCU). DHCF's Memorandum of Understanding (MOU) with the MFCU further outlines referral procedures and requirements.

In FY 2023, DHCF referred only one fraud case from an MCO to the MFCU, despite potential indicators of fraud in MCO operations. Notably, one MCO classified all overpayment recoveries as "waste" with no fraud classifications, raising questions about proper fraud identification. By contrast, DHCF made 145 referrals from sources other than MCOs, suggesting a significant disparity in how potential fraud is identified and escalated between MCO and non-MCO sources.

DHCF lacks a structured framework to consistently refer suspected fraud cases to the MFCU. This directly affects the District's ability to control Medicaid costs. For instance, when potential fraud cases are misclassified as "waste" or not properly escalated for investigation, the District may miss opportunities to find and address systematic fraud schemes. Misidentifying fraud could result in improper payments that increase program costs and waste taxpayer dollars.

Recommendation 8

We recommend that the Director, DHCF:

Establish a structured referral framework for MCO-reported fraud consistent with 42 CFR §§ 455.15(a) and 455.21(a)(1) requirements to refer suspected fraud cases to the MFCU.

Finding 9 – DHCF’s Monitoring was Ineffective in Preventing Beneficiaries from Simultaneous Enrollment in Both Medicaid and Alliance Programs

The DC Healthcare Alliance Program and Medicaid are separate health care programs with distinct eligibility requirements. According to the MCO contracts, Alliance beneficiaries over the age of twenty-one are ineligible for Medicaid. The Alliance program is specifically designed for low-income District residents who do not qualify for Medicaid or Medicare and have no other health insurance. DHCF, as the administrator of both programs, is responsible for maintaining effective eligibility monitoring systems to prevent improper enrollment and duplicate payments.

Our audit found 18 of 60 Adult Healthcare Alliance beneficiaries who were simultaneously enrolled in Medicaid for periods ranging from two to 12 months.¹⁷ This dual enrollment occurred despite contractual provisions explicitly saying that Alliance beneficiaries should not be eligible for Medicaid.¹⁸ When beneficiaries are enrolled in both programs simultaneously, the District could make capitation payments to MCOs for the same individuals under both programs.

The District lacks an effective enrollment monitoring system to identify and prevent duplicate program enrollment. DHCF’s current eligibility verification processes do not include systematic cross-checks between programs to identify potential duplicate enrollments.

This inadequate monitoring directly impacts the District’s ability to control Medicaid costs. The District may have made duplicate capitation payments for these 18 beneficiaries, paying both Medicaid and Alliance program costs for the same individuals. While DHCF officials stated such cases are rare, without systematic monitoring, the actual extent of duplicate enrollment and associated costs cannot be determined. Additionally, resources used for duplicate payments would reduce funds available for expanding services to other eligible beneficiaries.

¹⁷ See the “What We Reviewed” section for additional methodological information.

¹⁸ MCO Contracts § C.1.2.1.1.

Recommendation 9

We recommend that the Director, DHCF:

Independently monitor eligibility compliance by periodically auditing/reviewing enrollment data, ensuring that beneficiaries are only enrolled in programs for which they are eligible. For example, implement an automated cross-check system that verifies an applicant's enrollment status across both Medicaid and Alliance programs at the time of application and enrollment to prevent simultaneous participation in both programs.

Health Care Access and Service Delivery

A critical measure of the Managed Care system's effectiveness is whether beneficiaries can access health care services when they need them. Prior authorization processes can significantly impact the ability of beneficiaries to receive timely care. Our audit identified patterns in how MCOs handle prior authorization requests that directly affect health care access for District residents.

Finding 10 – Inadequate DHCF Oversight of Prior Authorization Could Impact Beneficiary Health Care Access

Federal regulation 42 CFR § 438.210(a)(3)(ii) requires state Medicaid agencies to have mechanisms to ensure that MCOs do not “arbitrarily deny or reduce the amount, duration, or scope of required service[s] solely because of diagnosis, type of illness, or condition of the beneficiary.”

During our audit period, we found that:

- The three MCOs denied 19,327 of the 38,958 (50 percent) prior authorization requests submitted by enrollees and providers. The District's 50 percent denial rate is significantly higher than the national average of 12.5 percent, which could create barriers to beneficiaries' access to health care services.¹⁹
- Enrollees and providers appealed 692 denial decisions.
- Of these appeals, 155 cases were overturned, 133 were withdrawn by the provider or enrollee, and 404 were upheld.
- The MCOs denied 12,962 prior authorization requests for services and drugs not approved on the fee schedules.

¹⁹ US Department of Health and Human Services, Office of Inspector General, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*, OEI-09-19-00350, July 2023, <https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf>.

- DHCF did not review any of these denial decisions or overturned appeals during our audit period.

DHCF relied on MCOs and external vendors for oversight of prior authorization decisions, without implementing its own review mechanisms. While federal regulations did not require DHCF to conduct a full audit of all MCO prior authorization decisions, the agency should have implemented oversight mechanisms such as statistical sampling of denials and systematic review of appealed cases to ensure MCOs are appropriately providing access to needed services, given the DC MCOs' 50 percent denial rate, which is four times higher than the national average denial rate of 12.5 percent.²⁰

The high denial rate and lack of District oversight directly impact beneficiaries' access to health care services. Without District review of denial decisions, DHCF lacks reasonable assurance that MCOs are not inappropriately restricting beneficiaries' access to necessary health care services. The fact that 22 percent of appealed cases were overturned indicates that nearly one in four initial denials were incorrect. When beneficiaries are denied appropriate care, they may eventually require more expensive interventions for conditions that could have been treated earlier at a lower cost. Additionally, the District may be paying MCOs for health care services that beneficiaries are unable to access.

Recommendation 10

We recommend that the Director, DHCF:

Implement a process to request and review all prior authorization denials to verify MCO compliance with coverage requirements, identify inappropriate denial patterns, and ensure beneficiaries have appropriate access to needed services.²¹

Recommendation 11

We recommend that the Director, DHCF:

Implement a systematic review of all appealed and overturned prior authorization cases to identify patterns, ensure proper corrective actions, and verify MCO compliance with appeal decisions.

²⁰ *Supra*, note 19.

²¹ This recommendation aligns with the GAO's April 2024 report "MEDICAID: Managed Care Plans' Prior Authorization Decisions for Children Need Additional Oversight" (GAO-24-106532), which found that states were not reviewing representative samples of denials to assess appropriateness.

Contract Administration and Readiness

Finding 11 – DHCF Contract Administrators Did Not Complete Certification Requirements

Contract Administrator (CA) appointment delegation letters require DHCF officials nominated as CAs to complete seventeen classroom training hours to be qualified to monitor contractor performance and ensure technical requirements are met within the contract period. The Green Book states that personnel need to possess and maintain relevant knowledge, skills, and abilities to accomplish their assigned responsibilities, which are gained largely from professional experience, training, and certifications.²²

Based on our review of DCHR employee training records, none of the DHCF contract administrators responsible for monitoring six contracts for and related to MCO administration completed the required seventeen classroom training hours during FY 2023. These contracts included the three Medicaid MCO contracts, the External Quality Review Organization broker contract, the enrollment broker contract, and the actuarial firm contract. DHCF officials stated that the required courses were not available in FY 2023. However, District officials stated they conducted training sessions every other week throughout FY 2023, though high demand created waiting lists.

The lack of proper CA certification and training relates to both of our audit objectives. First, inadequately trained CAs may have been less effective at monitoring MCO contract compliance, which may have allowed cost inefficiencies to go undetected. Any improper monitoring of "technical requirements under the contract ... at the price or within the estimated cost stipulated in the contract" may create a risk of overpayment or waste.²³ Second, CAs serve as points of contact for MCOs and have critical oversight responsibilities for ensuring contractors meet their obligations to provide "timely and appropriate care" to beneficiaries.²⁴ Without proper training, CAs may have been less effective at identifying and addressing service delivery issues that affect beneficiary access to care, undermining the District's ability to effectively oversee and administer the contracts.

²² [GAO Green Book § 4.02](#).

²³ OCP Delegation Letters (on file).

²⁴ MCO Contracts § C.1.3.3.

Recommendation 12

We recommend that the Director, DHCF:

Develop and implement a comprehensive training plan to ensure all Contract Administrators complete the required Office of Contracting and Procurement training courses within established timeframes.

Recommendation 13

We recommend that the Director, DHCF:

Establish an internal tracking system to monitor certification status and compliance with any other requirements for all staff serving as Contract Administrators for contracts for and related to MCO administration.

Finding 12 – DHCF Did Not Conduct Site Visits in its Readiness Assessments of MCOs

The MCO contracts signed at the start of FY 2023 require DHCF to conduct site visits as part of the readiness assessment that must be developed and certified for each MCO prior to enrolling any beneficiaries.²⁵ DHCF officials reported that they did not conduct site visits to all MCOs, as required by contract. While the agency issued a readiness report for one MCO in March 2023 due to that MCO's nearly 3-year absence from the District's Managed Care program, it did not complete readiness assessments or conduct site visits for the other MCOs.

DHCF officials explained that the incumbent MCOs did not undergo readiness assessments due to their continued participation in the program. Officials also cited challenges from the COVID-19 Public Health Emergency in FY 2023, including limited staff capacity, resource constraints, and staffing changes that discouraged site visits.

This noncompliance with contractual requirements directly impacted both areas that were the subject of this audit. Without comprehensive readiness assessments and site visits, DHCF lacked verification that MCOs had the appropriate systems, staffing, and processes in place to effectively manage costs and prevent waste. More broadly, the Medicaid Managed Care program is specifically designed to ensure MCOs can provide "timely and appropriate care"²⁶ to beneficiaries. By not conducting these assessments, DHCF could not verify whether all MCOs were adequately prepared to deliver services and maintain appropriate provider networks. Finally, failing to follow contractually

²⁵ MCO Contracts § H.11.6.3.1.

²⁶ *Supra*, note 23.

required oversight procedures undermines DHCF's accountability mechanisms and creates compliance risks for the Medicaid program.

Recommendation 14

We recommend that the Director, DHCF:

Develop and implement a documented site visit protocol for all MCOs, including a standardized assessment tool, staffing plan, and tracking mechanism to ensure contractually required readiness assessments are completed before each contract period begins, regardless of an MCO's incumbent status.

Recommendation 15

We recommend that the Director, DHCF:

Establish policies and procedures that define when virtual assessments can substitute for in-person visits, specify technology requirements to ensure comparable information collection, and include documentation standards that demonstrate fulfillment of contractual obligations.

Recommendation 16

We recommend that the Director, DHCF:

Develop a comprehensive MCO reassessment program that includes annual operational readiness reviews, quarterly performance monitoring, and targeted evaluations when significant changes occur in staffing, systems, or services to ensure continuous compliance with contract requirements and maintain service quality for Medicaid beneficiaries.

CONCLUSION

Our audit of DHCF's oversight of the Medicaid Managed Care health care delivery system revealed both strengths and opportunities for improvement. DHCF established foundational frameworks for quality assessment, monitoring, and compliance, creating basic structures necessary for program oversight. However, the agency's implementation of these frameworks contains gaps that directly impact the District's ability to control costs and ensure beneficiary access to care.

The findings demonstrate that DHCF has not fully operationalized all the internal controls needed to verify that the Managed Care system is reducing costs as intended. Incomplete policies and procedures, insufficient overpayment monitoring, inadequate data validation, limited fraud referral mechanisms, and duplicate enrollments all represent missed opportunities for cost containment. Similarly, DHCF's limited oversight of prior authorization

denials, inadequate contract administrator training, and incomplete MCO readiness assessments could create barriers to health care access for District residents.

By implementing the recommendations in this report, DHCF can strengthen its oversight capabilities through enhanced policies, improved data integrity measures, more robust monitoring systems, and strengthen staff capabilities through training. These improvements would enable the agency to more effectively fulfill its responsibility to ensure that the Managed Care health care delivery system achieves both objectives: reducing costs while increasing access to quality health care services for District Medicaid beneficiaries.

By addressing these findings, DHCF can better fulfill its mission to improve health outcomes through comprehensive, cost-effective, and quality healthcare services and ensure the creation of a more effective, accountable Medicaid program that serves the needs of District residents while responsibly managing public resources.



APPENDIX 1. FINDINGS

Table of Findings

No.	Finding
1	DHCF Developed a Framework to Assess Quality and Appropriateness of Care for the MCOs
2	DHCF Developed a Monitoring and Compliance Framework for the MCOs
3	DHCF Had a System of Oversight for the Managed Care Health Care System
4	Not All DHCF Division Policies and Procedures for Monitoring MCOs Were Complete
5	MCO Contracts Contained Incomplete Overpayment Recovery and Retention Policies
6	DHCF's Reviews of Overpayments Provide Limited Completeness and Accuracy Assurance
7	DHCF Has Opportunities to Strengthen its Monitoring and Oversight of MCO Overpayment Reporting
8	DHCF Can Strengthen Fraud Referral Processes to the MFCU
9	DHCF's Monitoring was Ineffective in Preventing Beneficiaries from Simultaneous Enrollment in Both Medicaid and Alliance Programs
10	Inadequate DHCF Oversight of Prior Authorization Could Impact Beneficiary Health Care Access
11	DHCF Contract Administrators Did Not Complete Certification Requirements
12	DHCF Did Not Conduct Site Visits in its Readiness Assessments of MCOs



APPENDIX 2. RECOMMENDATIONS

Table of Recommendations

Agency	No.	Recommendation	Status	Action Required	Finding
DHCF	1	Develop and implement comprehensive policies and procedures for all divisions that monitor MCOs, including detailed guidance on using oversight dashboards and monitoring tools to effectively assess cost reduction and health care access.	Open	Tracking implementation	4
DHCF	2	Modify the MCO contracts to specify the timeframes and documentation required for payment of overpayment recoveries to the District in situations where MCO retention is not permitted and establish procedures for refunding the federal share of these overpayments to CMS as required by federal regulations.	Open	Tracking implementation	5
DHCF	3	Implement a comprehensive data validation system that requires unique Transaction Control Numbers for all encounters across all systems, establishes clear standards for format and content, and ensures consistent tracking between encounter data and all reports to improve overpayment monitoring and cost recovery.	Open	Tracking implementation	6
DHCF	4	Independently audit the accepted and paid encounter data submitted through the MCOs' monthly financial reconciliation reports.	Open	Tracking implementation	6
DHCF	5	Establish a regular independent audit process for accepted and paid encounter data submitted through the MCOs' monthly financial reconciliation reports, rather than relying solely on attestations, to verify completeness, identify potential overpayments, and improve cost control.	Open	Tracking implementation	6
DHCF	6	Ensure MCOs receive uniform training and feedback about how to complete the PIMR data before submission to DHCF.	Open	Tracking implementation	6

July 10, 2025

Agency	No.	Recommendation	Status	Action Required	Finding
DHCF	7	Establish regular data quality audits of Program Integrity Monthly Reports that address inconsistent Transaction Control Number formatting, standardize fraud/waste/abuse classifications, and implement corrective actions for non-compliant MCO reporting to improve overpayment tracking and recovery.	Open	Tracking implementation	7
DHCF	8	Establish a structured referral framework for MCO-reported fraud consistent with 42 CFR §§ 455.15(a) and 455.21(a)(1) requirements to refer suspected fraud cases to the MFCU.	Open	Tracking implementation	8
DHCF	9	Independently monitor eligibility compliance by periodically auditing/reviewing enrollment data, ensuring that beneficiaries are only enrolled in programs for which they are eligible. For example, implement an automated cross-check system that verifies an applicant's enrollment status access both Medicaid and Alliance programs at the time of application and enrollment to prevent simultaneous participation in both programs.	Open	Tracking implementation	9
DHCF	10	Implement a process to request and review all prior authorization denials to verify MCO compliance with coverage requirements, identify inappropriate denial patterns, and ensure beneficiaries have appropriate access to needed services.	Open	Tracking implementation	10
DHCF	11	Implement a systematic review of all appealed and overturned prior authorization cases to identify patterns, ensure proper corrective actions, and verify MCO compliance with appeal decisions.	Open	Tracking implementation	10
DHCF	12	Develop and implement a comprehensive training plan to ensure all Contract Administrators complete the required Office of Contracting and Procurement training courses within established timeframes.	Open	Tracking implementation	11
DHCF	13	Establish an internal tracking system to monitor certification status and compliance with any other requirements for all staff serving as Contract Administrators for contracts for and related to MCO administration.	Open	Tracking implementation	11

July 10, 2025

Agency	No.	Recommendation	Status	Action Required	Finding
DHCF	14	Develop and implement a documented site visit protocol for all MCOs, including a standardized assessment tool, staffing plan, and tracking mechanism to ensure contractually required readiness assessments are completed before each contract period begins, regardless of an MCO's incumbent status.	Open	Tracking implementation	12
DHCF	15	Establish policies and procedures that define when virtual assessments can substitute for in-person visits, specify technology requirements to ensure comparable information collection, and include documentation standards that demonstrate fulfillment of contractual obligations.	Open	Tracking implementation	12
DHCF	16	Develop a comprehensive MCO reassessment program that includes annual operational readiness reviews, quarterly performance monitoring, and targeted evaluations when significant changes occur in staffing, systems, or services to ensure continuous compliance with contract requirements and maintain service quality for Medicaid beneficiaries.	Open	Tracking implementation	12



APPENDIX 3. MANAGEMENT RESPONSE

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



To: Daniel W. Lucas, D.C. Inspector General, D.C. Office of the Inspector General

From: Melanie Williamson, Chief of Staff, D.C. Department of Health Care Finance
Melanie Williamson

Date: August 8, 2025

Re: Draft OIG Report: Medicaid Managed Care Audit (OIG No. 23-1-07HT)

This memorandum responds to the DC Office of the Inspector General's July 10, 2025 Draft Audit Report, entitled "Opportunities for Strengthening District Oversight of Medicaid Managed Care Organizations." The audit period of review was Fiscal Year 2023 when the District was contracted with managed care organizations Amerigroup, Amerihealth, MedStar, and HSCSN. The Draft Report contains twelve findings, and sixteen corresponding recommendations. Findings 1-3 highlight the effective oversight frameworks that DHCF has established. Findings 4-12 contain substantive recommendations, and are addressed below. Through this document, DHCF responds to each finding and recommendation, specifying areas of agreement/disagreement, and the estimated date of completion for applicable corrective actions.

I. Oversight and Accountability

- a. **Finding 4: Not all DHCF Division Policies and Procedures for Monitoring MCOs Were Complete.** The DC OIG recommends that DHCF develop and implement comprehensive policies and procedures for all divisions that monitor MCOs, including detailed guidance on using oversight dashboards and monitoring tools to effectively assess cost reduction and health care access.
 - i. **DHCF Response:** DHCF disagrees in part with this finding.
 - 1. DHCF's managed care division does in fact has a well-established and documented compliance monitoring program in place, but broader policies and procedures across all divisions could further strengthen the managed care program.
 - 2. DHCF is reviewing the suite of activities that comprise its managed care compliance monitoring program, and identifying the corresponding policies and procedures that need to be strengthened.
 - 3. By March 1, 2026, DHCF will have completed the corresponding updates and additions to its compliance monitoring program.
- b. **Finding 5: MCO Contracts Contained Incomplete Overpayment Recovery and Retention Policies.** DC OIG recommends that DHCF modify its MCO contracts to comply with 42 C.F.R. Sec. 438.608(d)(3), by specifying the

timeframes and documentation required for payment of overpayment recoveries to the District, where MCO retention is not permitted.

i. **DHCF Response:** DHCF disagrees with this finding.

1. DHCF is already in compliance with 42 C.F.R. Sec. 438.608(d)(3).

The applicable contract language states:

C.5.33.1.6: “The Contractor shall submit *monthly* reports and a comprehensive *annual* report in a format determined by DHCF, on its recovery of overpayments, in accordance with 42 C.F.R. Sec. 438.608(d)(3),” and

C.5.33.1.7: “The Contractor shall have retention policies for the treatment of recoveries of all overpayments from the Contractor to a Provider, including specifically a retention policy for the treatment of recoveries of overpayments due to fraud, waste, or abuse in accordance with 42 C.F.R. § 438.608(d). Retention policies shall include the process, timeframes, and documentation required for reporting the recovery of all overpayments.

2. CMS confirmed DHCF’s compliance with 42 C.F.R. 438.608(d) at page 9 of its FY 22 Focused Program Integrity Review of the D.C. Medicaid Program Report, available at <https://www.cms.gov/files/document/washington-dc-fy22-focused-pi-review-report.pdf>.

II. Data Management and Reporting

a. **Finding 6: DHCF's Reviews of Overpayments Provide Limited Completeness and Accuracy Assurance.**

i. **DHCF Response:** DHCF disagrees with this finding.

1. DC OIG states that “DHCF could not accurately determine whether MCOs reported all identified overpayments as required. Our audit found 14,445 overpayment transaction control numbers (TCNs) that were missing from encounter data, including 7,081 transactions from the FY 2023 Program Integrity Monthly Report (PIMR) and 7,364 transactions from the FY 2024 PIMR” and that “without reliable overpayment data, DHCF cannot effectively verify MCOs are identifying and recovering all overpayments.”
2. First, it is important to note that the PIMR is fundamentally not a “Financial Reconciliation Report.” The function of the PIMR is to consolidate key program integrity activities to facilitate agency utilization review and investigatory priorities. Encounter data validation and reconciliation are conducted on an ongoing basis by the agency through multiple other functions and the PIMR report neither guides, nor is intended to supplant these activities. DHCF, along with its contracted Actuary, have extensively reviewed its data validation activities with the DC OIG.
3. It is incorrect to state that 7,081 transaction control numbers (TCN) were missing from the FY 23 PIMR, and 7,364 TCNs were

missing from the FY 24 PIMR. DHCF showed the DC OIG, in real time, all of the “missing” TCNs. The PIMR is a *retrospective* review, so the TCNs reviewed are for a *historical* period, and will not, by definition, align with *present* encounter data. The PIMR did not “fail” to include applicable TCNs. OIG initially presented DHCF with more than 11,000 TCNs it claimed were missing based on the FY2023 PIMRs. DHCF reviewed and identified all TCNs as being pulled directly from its own MMIS, so it is impossible for those claims to be missing from MMIS. DHCF met with the OIG and presented this data to the OIG, as well as sending OIG data files with all the TCNs showing that they were all present and accounted for in MMIS. DHCF has not been presented with the 7,364 TCNs allegedly missing from the FY24 PIMRs, but DHCF suspects that all those TCNs are from time periods outside of FY23, in which case they will not be found in the FY2023 claims data set that the OIG is running them up against. But they will still be found in MMIS because they come from MMIS.

b. Finding 7: DHCF Has Opportunities to Strengthen its Monitoring and Oversight of MCO Overpayment Reporting

i. DHCF Response: DHCF disagrees with this finding.

1. The DC OIG characterized the following as “inaccuracies” in MCO overpayment reporting that “limit DHCF’s ability to effectively monitor these payments,” which inflates the impact of largely immaterial data:

- a. One MCO PIMR had TCNs with file formatting that changed the last two digits to 00;

- i. **DHCF Response:** This was a one-time formatting error, whereby Excel “autocorrected” the TCNs to end in 00. Microsoft Excel has a formatting error that occasionally converts all digits greater than 15 to 15 digits, with the remaining digits being replaced by zeroes. The 17 digit TCN number’s last 2 digits were therefore converted to zeroes despite the MCO having uploaded the full TCN correctly. Once this issue was identified, DHCF worked with the MCO to timely update the data with the full TCN numbers. This is not a systemic issue.

- b. Another MCO classified all overpayment recoveries as “Waste” and not “Fraud or Abuse;”

- i. **DHCF Response:** This is immaterial for two reasons:
 - ii. First, the MCOs do not make the findings of “fraud” or “abuse.” Findings of fraud and abuse is determined via a separate process by the Medicaid Fraud Control Unit (MFCU), following a preliminary investigation by DHCF.

- iii. Second, in the period reviewed by DC OIG, DHCF considers all of the identified overpayments properly categorized as “waste.” The draft OIG Report does not identify any specific overpayment recoveries that it believes are nonetheless misclassified, so DHCF is unable to provide a further substantive response to the alleged errors.
- c. There were instances where (PIMR) TCNs had dates outside of FY23.
 - i. **DHCF Response:** Since DHCF Program Integrity division (DPI) audit activities are retrospective, there will always be TCNs in the PIMR that are outside of the present fiscal year. This is by design.

III. Program Integrity and Fraud Prevention

- a. **Finding 8: DHCF Can Strengthen its Fraud Referral Processes to the MFCU.**
 The DC OG states that “DHCF lacks a structured framework to consistently refer suspected fraud cases to the MFCU. This directly affects the District's ability to control Medicaid costs. For instance, when potential fraud cases are misclassified as "waste" or not properly escalated for investigation, the District may miss opportunities to find and address systematic fraud schemes. Misidentifying fraud could result in improper payments that increase program costs and waste taxpayer dollars.”
 - i. **DHCF Response:** DHCF disagrees with this finding.
 - 1. DHCF has a written fraud referral policy and procedure that is based on, and consistent with, federal regulatory requirements. *See* 42 C.F.R. Sec. 455.12 *et. seq.* This document has previously been provided to the OIG. DPI has an investigations branch that conducts preliminary investigations, consistent with 42 C.F.R. Sec. 455.14, to determine if credible allegations of fraud exist, and the payment suspension committee then convenes, consistent with our written policy and federal regulations, to determine if referral to law enforcement is justified under 42. C.F.R. Sec. 455.23. This framework is structured and effective.
 - 2. It is unclear from the DC OIG, how it suggests DHCF can improve its MCO fraud referral procedure. The fraud referral procedure is a stand-alone procedure, distinguished from other monitoring activities, such as overpayment review. The fraud referral procedure has been reviewed, in real time, with the MCOs during a dedicated meeting. The fraud referral procedure, which was provided to the DC OIG, includes:
 - a. Potential Provider Fraud and Abuse Referral Document Form;
 - b. Potential Provider Fraud and Abuse Referral Web Portal Form;
 - c. Assignment of a referral number from DHCF

3. Upon receipt of a MCO fraud referral, DHCF initiates its regulatorily required “preliminary investigation” to determine the credibility of the referral. If credible, then DHCF refers the matter to the MFCU. In addition, this finding fails to acknowledge activities undertaken by DHCF since FY2023 that are directly relevant to this finding. For example, OIG was informed of comprehensive trainings conducted by DHCF with each of the MCOs individually in FY24 that focused on properly classifying investigations as fraud/waste/abuse, instructed the MCOs on how to improve their internal investigations to identify additional fraud, and have resulted in significantly higher fraud referrals during this current FY. It is unclear to DHCF whether the activities taken since the review period OIG examined are sufficient to address OIG's concerns or, if they are not, how it failed to address those concerns.
4. The DC OIG's reference to the total number of fraud referrals in FY 23 is also incorrect, stating that “DHCF made 145 [fraud] referrals from sources other than MCOs, suggesting a significant disparity in how potential fraud is identified and escalated between MCO and non-MCO sources. This is incorrect, in FY 23 DHCF initiated 31 preliminary investigations, and referred 7 credible allegations of fraud to the MFCU. The “145” fraud referrals cited by the DC OIG is incorrect. In FY23, DHCF-DPI had 131 open investigations, inclusive of cases that had been opened in prior years and had not been closed due to ongoing activities, ongoing law enforcement investigations, or other reasons. Of those 131 cases, 7 cases were referred to the MFCU after DHCF determined that, pursuant to 42 C.F.R. section 455.23, credible allegations of fraud existed. None of those cases were MCO initiated investigations.
5. Regarding the alleged misclassification of waste, crucially, the OIG has not presented any evidence of improper classifications by the MCOs beyond the fact that one MCO classified all items on the PIMR as waste. Waste is a distinct and valid classification. Absent evidence that the classifications at issue were improper, DHCF cannot agree with the claim that misclassifications were made.
6. Lastly, all managed care network providers are required by federal law to be concurrently enrolled with the State Medicaid Agency. This means that every single managed care network provider, is also enrolled with DHCF. When DHCF develops its investigatory strategic plan, all enrolled providers are subject to review-managed care network providers are not excluded. DHCF determines its investigative priorities based on consideration of several factors, including but not limited to, aberrant utilization trends, or provider types/categories of services federally identified as high risk. Managed care network providers are absolutely not

without oversight from DHCF- they are subject to, and not excluded from the scope of fraud investigations.

b. Finding 9: DHCF’s Monitoring was Ineffective in Preventing Beneficiaries from Simultaneous Enrollment in Both Medicaid and Alliance Programs

ii. DHCF Response: DHCF disagrees with this finding.

1. It is unclear the sample, methodology, or data fields that were used by the DC OIG to conclude that “18/60” individuals had dual enrollment in the Alliance and Medicaid enrollment for periods ranging from two to twelve months. As was explained at length to the DC OIG, material to determining impermissible dual program enrollment, is to verify whether there are any “voided spans” during the subject enrollment period. Periods of apparent “dual enrollment, should be verified by checking if there is a corresponding “void span” in the District’s Medicaid management Information System (MMIS), that retroactively voids enrollment in one of the two subject programs due to dispositive information received subsequent to initial enrollment. For example, if an individual is enrolled in the Alliance Program from July 2023-September 2024, and at any time during this enrollment period, DHCF receives citizenship information that qualifies them for Medicaid, then the eligibility and enrollment system sends an automatic update to the claims processing system that “voids” the entirety of the Alliance span, and replaces it with a Medicaid span for the subject period. During DHCF’s multiple meetings with the DC OIG, it repeatedly explained that the “voided span” data field must be considered in order to validate any conclusion of duplicate enrollment. It does not appear that the DC OIG reviewed the “voided span” data at all. In the absence of this information, it is inaccurate to conclude that an individual had duplicate enrollment.

IV. Health Care Access and Service Delivery

a. Finding 10: Inadequate DHCF Oversight of Prior Authorization Could Impact Beneficiary Health Care Access

- i. DHCF Response:** DHCF disagrees with the methodology underlying this finding. The DC OIG’s calculations are incorrect. DHCF agrees to develop a process to review a representative sample of managed care prior authorization denials and appeals, on a periodic basis.

1. DC OIG states that in FY23, there were 19,327 denials out of 38,958 requests. However, of the 19,327 “denials,” 12,674 were for services categorically not covered under the D.C. State Plan for Medicaid. There is no basis to request a prior authorization for a non-covered service. Prior authorizations are only available for denied covered services. Further, 288 “denials” were either subsequently approved, or the request was withdrawn. Therefore, the 12,674 requests for non-covered services, and 288 approved or withdrawn requests should also be excluded from the total

“denials.” Properly excluding these cases 12,962 cases, yields a denial of 6,365 out of 38,958 requests, or a 16% denial rate, rather than the incorrect 50% rate asserted in the Draft Audit Report.

2. DHCF agrees to strengthen its health care access oversight by implementing a process to review, on a periodic basis, a representative sample of denied and appealed cases to identify potential, data supported access barriers for covered services. Estimated Completion Date: March 1, 2026.

b. Finding 11: DHCF Contract Administrators Did Not Complete Certification Requirements

i. DHCF Response: DHCF disagrees with this finding.

1. The subject Contract Administrators were previously certified and were unable to complete recertification requirements only due to lack of availability of OCP training for recertification. DHCF was unable to comply during the period of review due to reasons outside of its purview.
2. The D.C. Office of Contracts and Procurement (OCP) exclusively administers Contract Administrator (CA) training for applicable District employees. OCP did not make the applicable CA training available for District employees, during the period of review, which precluded timely completion of recertification.
3. Once the training became available, all CAs promptly enrolled and have since completed their recertification.

c. Finding 12: Finding 12 – DHCF Did Not Conduct Site Visits in its Readiness Assessments of MCOs.

i. DHCF Response: DHCF disagrees with this finding.

1. All readiness reviews were completed within required timeframes and in accordance with 42 CFR § 438.66 (1)(2)(3)(4).
2. During the specific period of review in this audit, only 1 MCO, Amerigroup, which was newly procured and absent from the program for 3 years, required a readiness review.
3. Amerigroup’s readiness review was completed in accordance with 42 CFR § 438.66 (1)(2)(3)(4). HSCSN, AmeriHealth, and MedStar were not subject to additional mandatory readiness reviews, as they were not newly contracted MCOs. The reviews had been completed prior to the period of review at issue in the audit.

Question 24

Please list all pending lawsuits in which the agency, or its officers or employees acting in their official capacities, are named as defendants. For each case, please provide the following:

- a. The case name;
- b. Court where the suit was filed;
- c. Case docket number;
- d. Case status; and
- e. A brief description of the case.

Pending Lawsuits Involving the Agency

There are currently four (4) pending lawsuits in which the agency, or its officers or employees acting in their official capacities, are named as defendants. Details for each case are provided below.

1. Salazar et al. v. District of Columbia

- Court: United States District Court for the District of Columbia
- Docket Number: Civil Action No. 93-452
- Status: Settlement Agreement executed; awaiting final approval by the Judge
- Case Description: Concerns compliance with federal requirements governing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

2. NB et al. v. District of Columbia

- Court: United States District Court for the District of Columbia
- Docket Number: Civil Action No. 10-1511
- Status: Parties have filed cross-motions for summary judgment; awaiting decision by the Judge
- Case Description: Addresses whether the District must issue notice to beneficiaries when a prescription request is denied at the point of sale.

3. Ivy Brown et al. v. District of Columbia

- Court: United States District Court for the District of Columbia
- Docket Number: Civil Action No. 10-2250
- Status: Discovery ongoing; the District has appealed the court's ruling
- Case Description: Examines whether the District is required to transition Medicaid recipients residing in nursing facilities to a less restrictive setting.

4. MJ v. District of Columbia

- Court: United States District Court for the District of Columbia
- Docket Number: Civil Action No. 18-1901
- Status: Discovery ongoing; the District has filed a motion for summary judgment and is awaiting the Judge's decision
- Case Description: Concerns whether the District must provide intensive community based services to children to prevent institutionalization.

Performance Oversight Hearing Question 25
Provider Payment Expenditure vs Budget
Fiscal Year 2025 and 2026

Cost Center (Parent Level 1)	Cost Center (Parent Level 1) Description	Cost Center Description	FY25 Revised Budget	FY25 Expenditures	Variance	FY26 Budget	FY26 Expenditures	Variance
H3201	MEDICAID PROVIDER PAYMENTS	ADULT DAY HEALTH	\$2,884,327	\$2,898,627	-\$14,300	\$3,479,134	\$680,391	\$2,798,743
		APRA ASARS: ADULT SUBSTANCE ABUSE	\$1,583,112	\$1,762,911	-\$179,799	\$295,329	\$832,701	-\$537,372
		APRA ASTEP: CHILD SUBSTANCE ABUSE	\$5,558	\$113,225	-\$107,668	\$11,393	\$51,958	-\$40,566
		BEHAVIORAL HEALTH TRANSFORMATION WAIVER - MEDICAID	\$1,772,186	\$1,772,186	\$0	\$10,099,405	\$407,928	\$9,691,477
		CASSIP	\$164,107,535	\$162,742,775	\$1,364,760	\$208,737,024	\$45,135,424	\$163,601,600
		CASSIP - CHIP	\$6,599,085	\$7,202,640	-\$603,555	\$5,313,538	\$1,796,127	\$3,517,411
		CLINIC SERVICES - MENTAL HEALTH	\$391,747	\$223,706	\$168,041	\$7,920,678	\$71,372	\$7,849,306
		CLINIC SERVICES - MENTAL HEALTH CHIP	\$2,300	\$2,551	-\$251	\$0	\$0	\$0
		CLINIC SERVICES - MHRS	\$175,675,545	\$175,675,545	\$0	\$183,105,002	\$36,982,233	\$146,122,770
		CLINIC SERVICES - MHRS CHIP	\$2,902,000	\$2,872,964	\$29,036	\$2,866,055	\$639,148	\$2,226,907
		CLINIC SERVICES - PRIVATE	\$5,155,280	\$6,140,158	-\$984,878	\$3,860,122	\$1,427,899	\$2,432,223
		CLINIC SERVICES - PRIVATE CHIP	\$4,217	\$3,823	\$395	\$724	\$20	\$704
		COBRA/RECIPIENT OOP	\$78,587	\$166,906	-\$88,319	\$99,846	\$52,896	\$46,951
		DDS HCBS ADMINISTRATIVE	\$913,932	\$760,819	\$153,113	\$0	\$0	\$0
		DENTAL SERVICES	\$4,275,919	\$4,285,028	-\$9,109	\$3,758,160	\$1,418,577	\$2,339,583
		DENTAL SERVICES - CHIP	\$263,933	\$143,974	\$119,959	\$44,740	\$16,733	\$28,007
		DHCF - HEALTH HOMES I	\$9,485	\$264	\$9,221	\$271,570	\$0	\$271,570
		DOULA SERVICES	\$127,486	\$0	\$127,486	\$690,655	\$0	\$690,655
		DUAL CHOICE	\$260,269,089	\$275,704,692	-\$15,435,603	\$312,083,593	\$76,597,116	\$235,486,477
		DURABLE MED EQUIP (DME)-MEDICAID	\$11,588,263	\$16,421,390	-\$4,833,127	\$9,487,141	\$5,221,927	\$4,265,214
		DURABLE MED EQUIP (DME)-MEDICAID - CHIP	\$3,196	\$2,352	\$844	\$2,697	\$334	\$2,364
		EMERGENCY HOSPITAL SERVICES	\$4,809,168	\$6,201,341	-\$1,392,172	\$7,113,635	\$1,650,323	\$5,463,311
		EMERGENCY HOSPITAL SERVICES - CHIP	\$141,653	\$152,269	-\$10,616	\$67,764	\$17,535	\$50,228
		EMERGENCY MEDICAID (NON MEDICAID POP.)	\$41,070,490	\$46,919,080	-\$5,848,590	\$6,631,303	\$9,354,857	-\$2,723,554
		EMERGENCY MEDICAID GROUP VIII	\$78	\$0	\$78	\$46,645,467	\$0	\$46,645,467
		EPD WAIVER	\$172,567,604	\$186,213,200	-\$13,645,596	\$203,571,773	\$53,802,477	\$149,769,296
		EPSDT SCREENING SERVICES - CHIP	\$19,347	\$11,578	\$7,769	\$33,203	\$2,275	\$30,928
		EPSDT-MEDICAID	\$475,567	\$471,968	\$3,599	\$827,211	\$124,297	\$702,914
		FEDERALLY-QUALIFIED HEALTH CENTER	\$8,693,308	\$8,431,496	\$261,812	\$46,775,214	\$4,046,247	\$42,728,967
		FEDERALLY-QUALIFIED HEALTH CENTER - CHIP	\$191,722	\$157,369	\$34,353	\$2,184,076	\$13,250	\$2,170,826
		HCBS ARPA HCRIA INITIATIVES	\$131,500	\$131,500	\$0	\$0	\$0	\$0
		HCBS ARPA LTC IMPROVEMENTS	\$224,775	\$0	\$224,775	\$0	\$0	\$0
		HCBS OVERSIGHT & IMPLEMENTATION	\$0	-\$17	\$17	\$0	\$0	\$0
		HEALTH HOMES II	\$1,843,402	\$1,968,612	-\$125,210	\$2,508,582	\$453,018	\$2,055,564
		HOME HEALTH SERVICES	\$6,619,036	\$6,228,488	\$390,548	\$8,700,905	\$1,340,763	\$7,360,142
		HOME HEALTH SERVICES - CHIP	\$42,170	\$0	\$42,170	\$33,717	\$0	\$33,717
		HOSPICE BENEFITS	\$2,756,132	\$3,344,411	-\$588,279	\$6,031,587	\$574,033	\$5,457,554
		HOSPITAL SUPPORT	\$0	\$97,209	-\$97,209	\$0	\$0	\$0
		ICF PRIVATE	\$97,017,116	\$96,953,321	\$63,794	\$103,788,453	\$24,624,778	\$79,163,675
		ICF SUPPLEMENTAL PAYMENTS	\$2,600,000	\$0	\$2,600,000	\$2,600,000	\$0	\$2,600,000
		IDD WAIVER	\$266,378,457	\$267,629,798	-\$1,251,341	\$283,291,008	\$61,562,841	\$221,728,167
		IFS WAIVER	\$1,845,485	\$1,444,800	\$400,686	\$2,035,686	\$351,332	\$1,684,354
		IMMIGRANT KIDS	\$19,420,943	\$22,361,961	-\$2,941,018	\$0	\$0	\$0
		INPATIENT - DSH PAYMENTS	\$36,110,000	\$30,547,830	\$5,562,170	\$0	\$0	\$0
		INPATIENT - GME PAYMENTS	\$7,640,907	\$9,015,690	-\$1,374,783	\$26,961,048	\$9,000,000	\$17,961,048
		INPATIENT CHIP	\$710,048	\$912,790	-\$202,742	\$211,527	\$110,306	\$101,221
		INPATIENT IN STATE	\$120,858,013	\$124,803,660	-\$3,945,648	\$143,113,601	\$29,754,673	\$113,358,928
		LABORATORY & RADIOLOGICAL SERVICES	\$5,013,877	\$5,293,538	-\$279,662	\$5,230,596	\$1,397,007	\$3,833,588
		LABORATORY & RADIOLOGICAL SERVICES -CHIP	\$54,496	\$56,429	-\$1,932	\$18,055	\$5,016	\$13,039
		MANAGED CARE ORGANIZATIONS (MCO)	\$649,788,638	\$564,134,081	\$85,654,556	\$876,706,463	\$109,195,361	\$767,511,102
		MANAGED CARE ORGANIZATIONS (MCO) - CHIP	\$53,830,003	\$55,481,011	-\$1,651,009	\$92,465,905	\$10,801,828	\$81,664,077
		MCO- EXPANSION POPLULATION	\$21,090,293	\$21,174,328	-\$84,035	\$32,468,651	\$6,789,809	\$25,678,842
		MCO-ABD	\$287,598,224	\$313,911,226	-\$26,313,003	\$457,895,309	\$118,125,529	\$339,769,780
		MCO-NEWLY ELIGIBLE	\$707,759,983	\$694,082,867	\$13,677,116	\$1,096,926,020	\$215,647,611	\$881,278,408
		MEDICAID PART A	\$16,679,612	\$16,832,823	-\$153,211	\$22,888,672	\$4,061,625	\$18,827,047
		MEDICAID PART B	\$80,149,232	\$80,086,067	\$63,164	\$91,899,548	\$20,661,756	\$71,237,792
		MEDICAID PART B - NON FFP	\$4,867,553	\$4,767,971	\$99,581	\$7,209,879	\$1,127,062	\$6,082,817
		MENTAL HEALTH FACILITY - CHIP	\$71,804	\$40,955	\$30,849	\$55,277	\$0	\$55,277

		MENTAL HEALTH FACILITY SERVICES	\$686,478	\$650,566	\$35,912	\$1,659,909	\$184,699	\$1,475,210	
		MENTAL HEALTH FACILITY SERVICES - DSH	\$0	\$0	\$0	\$0	\$0	\$0	
		NON-EMERGENCY MEDICAL TRANSPORT. - CHIP	\$102,337	\$112,006	-\$9,669	\$129,045	\$23,010	\$106,035	
		NON-EMERGENCY MEDICAL TRANSPORTATION	\$14,923,441	\$15,059,372	-\$135,931	\$24,815,201	\$3,998,277	\$20,816,924	
		NURSE MID-WIFE	\$72,382	\$82,764	-\$10,382	\$81,796	\$11,178	\$70,618	
		NURSE PRACTITIONER SERVICES	\$4,755,393	\$6,250,456	-\$1,495,062	\$3,861,251	\$1,570,865	\$2,290,386	
		NURSE PRACTITIONER SERVICES - CHIP	\$10,275	\$9,445	\$830	\$9,194	\$1,147	\$8,047	
		NURSING FACILITY IN STATE	\$321,851,299	\$328,908,440	-\$7,057,141	\$327,219,606	\$87,564,221	\$239,655,384	
		NURSING HOME QUALITY OF CARE SERVICES	\$200,000	\$164,801	\$35,199	\$200,000	-\$13,419	\$213,419	
		OPTIONAL STATE SUPPLEMENT PAYMENTS	\$5,403,324	\$4,766,967	\$636,357	\$5,403,324	\$1,253,008	\$4,150,316	
		OTHER PRACTITIONERS' SERVICES	\$792,036	\$815,651	-\$23,615	\$6,833,402	\$152,854	\$6,680,548	
		OTHER PRACTITIONERS' SERVICES CHIP	\$225,745	\$361,733	-\$135,988	\$2,905	\$550	\$2,355	
		OUTPATIENT HOSPITAL CHIP	\$196,609	\$261,009	-\$64,400	\$66,331	\$19,621	\$46,710	
		OUTPATIENT HOSPITAL IN STATE	\$16,336,928	\$22,222,387	-\$5,885,459	\$68,109,039	\$10,670,399	\$57,438,640	
		PART-D CLAWBACK	\$28,301,502	\$28,563,378	-\$261,876	\$36,413,380	\$4,928,890	\$31,484,490	
		PERMANENT SUPPORTIVE HOUSING	\$22,691,075	\$23,814,052	-\$1,122,977	\$30,107,997	\$6,050,693	\$24,057,303	
		PERMANENT SUPPORTIVE HOUSING-GROUP V111	\$10,573,278	\$10,746,349	-\$173,071	\$16,962,824	\$2,717,072	\$14,245,752	
		PERSONAL CARE SERVICES	\$141,604,996	\$144,051,472	-\$2,446,476	\$100,714,440	\$28,726,314	\$71,988,126	
		PHYSICAL THERAPY	\$72,502	\$49,126	\$23,376	\$75,739	\$12,970	\$62,769	
		PHYSICAL THERAPY - CHIP	\$1,860	\$1,180	\$680	\$1,273	\$0	\$1,273	
		PHYSICIAN SERVICES CHIP	\$80,920	\$102,890	-\$21,970	\$36,593	\$13,410	\$23,183	
		PHYSICIAN SERVICES-MEDICAID	\$21,036,111	\$15,960,998	\$5,075,113	\$14,571,190	\$5,135,355	\$9,435,835	
		PRESCRIBED DRUGS	\$50,351,460	\$28,245,973	\$22,105,488	\$80,942,788	-\$5,453,840	\$86,396,628	
		PRESCRIBED DRUGS - CHIP	\$356,998	\$116,056	\$240,942	\$2,585,908	\$21,067	\$2,564,840	
		PRIVATE DUTY NURSING	\$16,769,033	\$17,711,725	-\$942,692	\$23,650,041	\$4,553,362	\$19,096,680	
		PROGRAM OF ALL-INCLUSIVE CARE (PACE)	\$5,580,246	\$5,855,661	-\$275,415	\$7,481,163	\$999,279	\$6,481,884	
		PROSTHETC DVCS,DENTURES,EYEGLASSES-CHIP	\$5,655	\$8,714	-\$3,059	\$1,778	-\$60	\$1,838	
		PROSTHETIC DEVICES, DENTURES, EYEGLASSES	\$1,366,608	\$1,255,783	\$110,824	\$1,753,741	\$316,827	\$1,436,914	
		PSYCHIATRIC RESIDENTIAL TREATMENT FACIL.	\$1,169,758	\$1,141,000	\$28,757	\$1,632,734	\$479,695	\$1,153,038	
		PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY - CHIP	\$231,198	\$227,722	\$3,476	\$16,163	\$0	\$16,163	
		STERILIZATIONS	\$6,644	\$16,899	-\$10,255	\$4,328	\$0	\$4,328	
		MEDICAID PROVIDER PAYMENTS Total	\$3,923,439,507	\$3,886,290,763	\$37,148,744	\$5,084,360,023	\$1,009,865,841	\$4,074,494,182	
H3202	PUBLIC PROVIDER PAYMENTS	CHILD & FAMILY SERVICES (CFSA)	\$500,000	\$552,608	-\$52,608	\$1,000,000	\$19,271	\$980,729	
		DBH - DENTAL OPTION	\$22,700	\$0	\$22,700	\$0	\$0	\$0	
		DBH - REHAB OPTION	\$2,000,000	\$2,128,971	-\$128,971	\$2,000,000	\$427,894	\$1,572,106	
		DBH - REHAB OPTION - CHIP	\$11,600	\$16,552	-\$4,952	\$8,052	\$0	\$8,052	
		DC CHARTER SCHOOLS	\$4,000,000	\$5,739,468	-\$1,739,468	\$7,000,000	\$1,528,207	\$5,471,793	
		DC CHARTER SCHOOLS - CHIP	\$54,772	\$54,772	\$0	\$1,000,000	\$36,415	\$963,585	
		DC PUBLIC SCHOOLS	\$8,000,000	\$25,779,729	-\$17,779,729	\$1,000,000	\$744,246	\$255,754	
		DC PUBLIC SCHOOLS - CHIP	\$200,000	\$835,323	-\$635,323	\$1,000,000	\$0	\$1,000,000	
		FIRE & EMS SVS. (AMBULANCE)	\$84,100,000	\$90,126,351	-\$6,026,351	\$87,291,466	\$8,759,851	\$78,531,615	
		FIRE & EMS SVS. (AMBULANCE) - CHIP	\$859,654	\$859,654	\$0	\$1,000,000	\$141,097	\$858,903	
		OSSE-CHILDREN W/SPCL NEEDS TRNSPT	\$7,944,260	\$9,824,653	-\$1,880,393	\$26,000,000	\$1,450,385	\$24,549,615	
		OSSE-CHILDREN W/SPCL NEEDS TRNSPT - CHIP	\$717,665	\$717,665	\$0	\$2,000,000	\$311,476	\$1,688,524	
		SAINT ELIZABETHS HOSPITAL	\$1,300,000	\$882,968	\$417,033	\$2,000,000	\$0	\$2,000,000	
		ST ELIZBETHS HSPTL DSH (M.H. FCLTY DSH)	\$4,987,394	\$5,766,606	-\$779,212	\$4,581,595	\$0	\$4,581,595	
		PUBLIC PROVIDER PAYMENTS Total	\$114,698,044	\$143,285,318	-\$28,587,274	\$135,881,113	\$13,418,842	\$122,462,271	
H3203	ALLIANCE PROVIDER PAYMENT	ALLIANCE EMERGENCY MEDICAL TRANSPORT	\$2,416,093	\$2,118,264	\$297,829	\$0	\$0	\$0	
		MCO ALLIANCE	\$157,728,009	\$159,904,536	-\$2,176,527	\$0	\$0	\$0	
		ALLIANCE PROVIDER PAYMENT Total	\$160,144,102	\$162,022,800	-\$1,878,698	\$0	\$0	\$0	
Grand Total			\$4,198,281,653	\$4,191,598,881	\$6,682,772	\$5,220,241,136	\$1,023,284,683	\$4,196,956,453	

-\$19,519,197

25. Please provide an Account Group level breakout of budget and expenditures for DIFS Cost Center Codes: H3201 (Medicaid Provider Payments), H3202 (Public Provider Payments), and H3203 (Alliance Provider Payments) for FY 2025 and FY 2026, to date.

a. Please provide all information related to assumptions that inform the Medicaid Provider Payment budgets.

Response:

Please see Attachment 1 to Q25. In general, DHCF develops fee-for-service budgets by computing the historic average cost of utilization per beneficiary and projecting that forward and then multiplying that projected per beneficiary cost by the projected number of beneficiaries. For waiver programs, DHCF uses the budget neutrality models developed as part of the waiver applications and renewals based on users, average units per user, and average cost per unit to project the budgets into the future. For managed care programs, DHCF uses the latest capitation rate projections from the department's contracted actuarial firm and modifies those for anticipated changes in policy, cost, and/or utilization. We then multiply those modified rates by the projected managed care beneficiaries.

26. For FY 2025 and FY 2026 to date, please provide the Monthly Medicaid enrollment for both FFS and each MCO, broken down by eligibility category.

Response:

Enrollment information is available on the DHCF website at <https://dhcf.dc.gov/node/1180991>.

29. For FY 2025 and FY 2026, to date, please provide the following data related to network adequacy in the Medicaid provider network:

- a. Results of the most recent audit(s) related to network adequacy.**
- b. Metrics used to measure network adequacy, including geographic proximity, provider-to-enrollee requirements, and/or timely provider appointments and how FFS and MCO providers meet or do not meet these metrics.**
- c. Any penalties issued or enforcement measures taken by DHCF against MCOs in relation to network adequacy.**
- d. Status update on DHCF's efforts to create a consolidated Provider Directory, which was noted as a plan in FY 2024's performance oversight responses; and**
- e. Any current or future changes to procedures and policies related to network adequacy measurement or enforcement in FY 2025 and FY 2026, to date.**

Response:

DHCF tracks and monitors its Managed Care Plans' (MCPs) provider network and compliance according to network adequacy standards prescribed in Federal Regulations. Qlarant, the District's contracted External Quality Review Organization (EQRO), evaluates provider networks to gauge compliance, including conducting an annual network adequacy survey. The goal is to ensure MCP enrollees have adequate access to health care including preventative, diagnostic and treatment services through an evaluation of provider availability, provider directory accuracy, and timely access to appointments and services for enrollees.

In addition, in FY25 DHCF collected data to enhance oversight of MCP's provider networks including the following:

- Network Provider Report: This quarterly report collects information about each MCP's entire network of providers to include provider types and specialty.
- Provider Termination Report: This monthly report details provider terminations (providers who left the network) in order to monitor changes in the MCPs' networks.

a. Results of the most recent audit(s) related to network adequacy.

Based on reviewed data, all MCPs demonstrated sufficient provider networks including compliance with the following:

- Adult and pediatric primary care geographic access standards.
- Adult and pediatric primary care provider-to-enrollee ratio standards.
- Primary care provider network requirements.
- Aggregate rates for Adult PCP routine appointment (88%) and Pediatric PCP routine appointment compliance (94%)
- Aggregate rates for Adult PCP urgent appointments (88%) and Pediatric PCP urgent appointments (87%)

b. Metrics used to measure network adequacy, including geographic proximity, provider-to-enrollee requirements, and/or timely provider appointments and how FFS and MCP providers meet or do not meet these metrics.

The table below lists the modified metrics used to measure network adequacy.

Table 1: Network Adequacy Matrix

MCP Contract Reference	Contract Requirement	Compliance Status
Provider Network		
Geographic Standards Mileage and Travel Standards DCHFP: C.3.161 CASSIP: C.3.177	A source of treatment within five (5) miles of an Enrollee's residence or no more than thirty (30) minutes Travel Time by public transportation, unless specified in the Contract.	Met
Geographic Standards: Mileage and Travel DCHFP: C.5.29.8.1.6 CASSIP: C.5.107.1.7	Psychiatric Residential Treatment Facilities and Substance Use Disorder Residential treatment facilities at all ASAM levels of care within 30 miles from the enrollee's residence OR 60 minutes travel time by public transportation.	Met
Provider -to -Enrollee Ratio: Primary Care Provider (PCP): DCHF: C.5.29.2.7.11 CASSIP: C.5.100.11	At least one (1) full-time equivalent PCP, regardless of specialty type, for every five hundred (500) Enrollees, and there must be one (1) full-time equivalent PCP with pediatric training and/or experience for every five hundred (500) children and adolescents through the age of twenty (20) within the Mileage and Time Travel Standards.	Met
Provider-to-Enrollee Ratio: Dental Provider DCHFP: C.5.29.2.7.11.1 CASSIP: C.5.100.11.1	At least one (1) full-time equivalent dentist for every seven hundred and fifty (750) children and adolescent who serves the pediatric population through the age of twenty (20) within the Mileage and Time Travel Standards.	Met
Timely Access to Care		
Routine Primary Care	Adult and children enrollees	MCP performance

DCHFP: C.5.29.18.5.2, C.5.29.18.10 CASSIP: C.5.116.10	should have access to a routine, well health examination within 30 days of request	declined in both measures. ***Adult: Decreased from 93% to 88% Children: 97% to 94%
Urgent Primary Care DCHFP: C.3.237 CASSIP: C.5.116.6	Adults and children enrollees should have access to urgent medical care within 24 hours of request.	*** A marginal decline was noted in the Pediatric PCP Urgent Appointment Compliance measure (from 88% to 87%).

*** DC aggregate is the combined performance of the four (4) MCPs – AmeriHealth Caritas DC, Health Services for Children with Special Needs, MedStar Family Choice DC and Wellpoint DC (formerly Amerigroup DC). DHCF will address issues specific to each MCP, accordingly.

c. Any penalties issued or enforcement measures taken by DHCF against MCOs in relation to network adequacy.

None.

d. Status update on DHCF's efforts to create a consolidated Provider Directory, which was noted as a plan in FY 2024's performance oversight responses; and

DHCF successfully collected data needed to develop and create the consolidated Provider Directory and expects to conclude this work soon.

e. Any current or future changes to procedures and policies related to network adequacy measurement or enforcement in FY 2025 and FY 2026, to date.

The 2024 CMS Managed care Rule includes a new requirement for availability of telehealth, telemedicine, e-visits, and other technological access. Contract modifications to align with the new requirements are in progress with implementation planned for Q2 FY26.

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS
LEE MONTESSORI PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 1,849.27	\$ 1,409.19	\$ -	51
LEE MONTESSORI PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 2,993.52	\$ 2,353.97	\$ -	88
LEE MONTESSORI PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 8,370.94	\$ 6,550.03	\$ -	239
LEE MONTESSORI PUBLIC CHARTER SCHOOL				\$ 13,213.73	\$ 10,313.19	\$ -	378
STATESMEN COLLEGE PREPARATORY ACADEMY	2024-11	PAID	01 - 30 DAYS	\$ 4,649.16	\$ 3,580.09	\$ -	198
STATESMEN COLLEGE PREPARATORY ACADEMY	2024-12	PAID	01 - 30 DAYS	\$ 58.48	\$ 44.56	\$ -	1
STATESMEN COLLEGE PREPARATORY ACADEMY	2025-06	PAID	01 - 30 DAYS	\$ 29.16	\$ 24.30	\$ -	1
STATESMEN COLLEGE PREPARATORY ACADEMY	2025-12	PAID	01 - 30 DAYS	\$ 643.18	\$ 532.82	\$ -	22
STATESMEN COLLEGE PREPARATORY ACADEMY				\$ 5,379.98	\$ 4,181.77	\$ -	222
ACHIEVEMENT PREPARATORY ACADEMY	2024-11	PAID	01 - 30 DAYS	\$ 4,529.95	\$ 3,451.64	\$ -	109
ACHIEVEMENT PREPARATORY ACADEMY	2025-06	PAID	01 - 30 DAYS	\$ 992.07	\$ 755.95	\$ -	30
ACHIEVEMENT PREPARATORY ACADEMY	2025-08	PAID	01 - 30 DAYS	\$ 685.26	\$ 522.17	\$ -	27
ACHIEVEMENT PREPARATORY ACADEMY	2025-12	PAID	01 - 30 DAYS	\$ 12,908.47	\$ 9,836.09	\$ -	602
ACHIEVEMENT PREPARATORY ACADEMY				\$ 19,115.75	\$ 14,565.85	\$ -	768
SAINT ELIZABETH HOSPITAL	2024-10	PAID	01 - 30 DAYS	\$ 674,856.00	\$ 187,223.40	\$ -	16
SAINT ELIZABETH HOSPITAL	2024-10	PAID	31-90 DAYS	\$ 76,632.00	\$ 21,259.80	\$ -	2
SAINT ELIZABETH HOSPITAL	2024-11	PAID	01 - 30 DAYS	\$ 1,161,840.00	\$ 322,326.00	\$ -	24
SAINT ELIZABETH HOSPITAL	2025-02	PAID	01 - 30 DAYS	\$ 981,384.00	\$ 272,262.60	\$ -	12
SAINT ELIZABETH HOSPITAL	2025-03	PAID	01 - 30 DAYS	\$ 1,967,712.00	\$ 545,896.80	\$ -	32
SAINT ELIZABETH HOSPITAL	2025-07	PAID	01 - 30 DAYS	\$ 1,809,504.00	\$ 502,005.60	\$ -	24
SAINT ELIZABETH HOSPITAL	2026-01	PAID	01 - 30 DAYS	\$ 1,816,920.00	\$ 504,063.00	\$ -	44
SAINT ELIZABETH HOSPITAL				\$ 8,488,848.00	\$ 2,355,037.20	\$ -	154
D.C. PUBLIC SCHOOLS	2024-10	PAID	01 - 30 DAYS	\$ 1,378,893.45	\$ 1,058,998.56	\$ -	6,550
D.C. PUBLIC SCHOOLS	2025-05	PAID	01 - 30 DAYS	\$ 121,826.28	\$ 93,521.81	\$ -	585
D.C. PUBLIC SCHOOLS	2025-07	PAID	01 - 30 DAYS	\$ 2,033,852.32	\$ 1,564,511.57	\$ -	11,487
D.C. PUBLIC SCHOOLS	2025-08	PAID	01 - 30 DAYS	\$ 4,408,871.81	\$ 3,398,412.11	\$ -	16,318
D.C. PUBLIC SCHOOLS	2025-09	PAID	01 - 30 DAYS	\$ 1,675,776.55	\$ 1,290,478.72	\$ -	10,116
D.C. PUBLIC SCHOOLS	2025-10	PAID	01 - 30 DAYS	\$ 238,841.88	\$ 184,084.58	\$ -	119
D.C. PUBLIC SCHOOLS	2025-11	PAID	01 - 30 DAYS	\$ 126,809.91	\$ 89,090.38	\$ -	657
D.C. PUBLIC SCHOOLS	2025-11	PAID	31-90 DAYS	\$ 9,891.84	\$ 1,793.92	\$ -	10
D.C. PUBLIC SCHOOLS	2025-11	PAID	91+ DAYS	\$ 19,417.06	\$ 3,521.42	\$ -	110
D.C. PUBLIC SCHOOLS	2025-12	PAID	01 - 30 DAYS	\$ 1,057,172.01	\$ 809,344.44	\$ -	6,135
D.C. PUBLIC SCHOOLS	2026-01	PAID	01 - 30 DAYS	\$ 6,311.48	\$ 3,899.55	\$ -	23
D.C. PUBLIC SCHOOLS				\$ 11,077,664.59	\$ 8,497,657.06	\$ -	52,110

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS
DC FIRE DEPT AMBULANCE SVC	2024-10	PAID	01 - 30 DAYS	\$ 8,433,969.44	\$ 6,222,251.15	\$ -	7,543
DC FIRE DEPT AMBULANCE SVC	2024-10	PAID	31-90 DAYS	\$ 5,654.48	\$ 5,089.03	\$ -	4
DC FIRE DEPT AMBULANCE SVC	2024-10	PAID	91+ DAYS	\$ 6,303.76	\$ 414.05	\$ -	8
DC FIRE DEPT AMBULANCE SVC	2024-11	PAID	01 - 30 DAYS	\$ 6,511,385.95	\$ 4,833,278.66	\$ -	5,903
DC FIRE DEPT AMBULANCE SVC	2024-11	PAID	91+ DAYS	\$ 12,865.10	\$ 2,090.47	\$ -	14
DC FIRE DEPT AMBULANCE SVC	2024-12	PAID	01 - 30 DAYS	\$ 7,515,457.96	\$ 5,510,433.04	\$ -	6,764
DC FIRE DEPT AMBULANCE SVC	2024-12	PAID	31-90 DAYS	\$ 5,041.45	\$ 2,353.64	\$ -	4
DC FIRE DEPT AMBULANCE SVC	2024-12	PAID	91+ DAYS	\$ 8,584.34	\$ 1,117.68	\$ -	12
DC FIRE DEPT AMBULANCE SVC	2025-01	PAID	01 - 30 DAYS	\$ 8,449,192.66	\$ 6,299,167.09	\$ -	7,604
DC FIRE DEPT AMBULANCE SVC	2025-01	PAID	91+ DAYS	\$ 9,509.07	\$ 1,363.81	\$ -	10
DC FIRE DEPT AMBULANCE SVC	2025-02	PAID	01 - 30 DAYS	\$ 7,061,904.85	\$ 5,305,816.53	\$ -	6,057
DC FIRE DEPT AMBULANCE SVC	2025-02	PAID	91+ DAYS	\$ 11,498.54	\$ 2,559.43	\$ -	12
DC FIRE DEPT AMBULANCE SVC	2025-03	PAID	01 - 30 DAYS	\$ 6,861,615.70	\$ 5,357,666.06	\$ -	5,962
DC FIRE DEPT AMBULANCE SVC	2025-03	PAID	91+ DAYS	\$ 11,812.32	\$ 1,936.87	\$ -	12
DC FIRE DEPT AMBULANCE SVC	2025-04	PAID	01 - 30 DAYS	\$ 10,071,257.07	\$ 8,080,799.39	\$ -	8,914
DC FIRE DEPT AMBULANCE SVC	2025-04	PAID	31-90 DAYS	\$ 2,350.37	\$ 426.26	\$ -	2
DC FIRE DEPT AMBULANCE SVC	2025-04	PAID	91+ DAYS	\$ 19,458.04	\$ 3,293.15	\$ -	20
DC FIRE DEPT AMBULANCE SVC	2025-05	PAID	01 - 30 DAYS	\$ 6,982,266.98	\$ 5,523,717.96	\$ -	5,819
DC FIRE DEPT AMBULANCE SVC	2025-05	PAID	31-90 DAYS	\$ 4,734.78	\$ 2,203.64	\$ -	4
DC FIRE DEPT AMBULANCE SVC	2025-05	PAID	91+ DAYS	\$ 6,337.89	\$ 1,281.72	\$ -	6
DC FIRE DEPT AMBULANCE SVC	2025-06	PAID	01 - 30 DAYS	\$ 6,098,482.92	\$ 4,798,800.42	\$ -	4,945
DC FIRE DEPT AMBULANCE SVC	2025-06	PAID	31-90 DAYS	\$ 2,350.37	\$ 211.54	\$ -	2
DC FIRE DEPT AMBULANCE SVC	2025-06	PAID	91+ DAYS	\$ 12,894.51	\$ 1,987.56	\$ -	16
DC FIRE DEPT AMBULANCE SVC	2025-07	PAID	01 - 30 DAYS	\$ 8,584,889.08	\$ 6,634,885.51	\$ -	7,027
DC FIRE DEPT AMBULANCE SVC	2025-07	PAID	91+ DAYS	\$ 9,197.24	\$ 1,241.65	\$ -	8
DC FIRE DEPT AMBULANCE SVC	2025-08	PAID	01 - 30 DAYS	\$ 6,646,557.98	\$ 5,267,483.49	\$ -	5,383
DC FIRE DEPT AMBULANCE SVC	2025-08	PAID	91+ DAYS	\$ 5,075.49	\$ 456.81	\$ -	4
DC FIRE DEPT AMBULANCE SVC	2025-09	PAID	01 - 30 DAYS	\$ 2,497,656.62	\$ 1,859,653.57	\$ -	2,005
DC FIRE DEPT AMBULANCE SVC	2025-09	PAID	31-90 DAYS	\$ 2,384.41	\$ 1,816.92	\$ -	2
DC FIRE DEPT AMBULANCE SVC	2025-09	PAID	91+ DAYS	\$ 17,495.37	\$ 1,970.60	\$ -	18
DC FIRE DEPT AMBULANCE SVC	2025-10	PAID	01 - 30 DAYS	\$ 1,713,835.83	\$ 993,747.04	\$ -	1,501
DC FIRE DEPT AMBULANCE SVC	2025-10	PAID	31-90 DAYS	\$ 2,214.21	\$ 401.56	\$ -	2
DC FIRE DEPT AMBULANCE SVC	2025-10	PAID	91+ DAYS	\$ 10,712.42	\$ 1,437.26	\$ -	13
DC FIRE DEPT AMBULANCE SVC	2025-11	PAID	01 - 30 DAYS	\$ 5,727,195.52	\$ 3,905,382.67	\$ -	4,843

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS
DC FIRE DEPT AMBULANCE SVC	2025-11	PAID	91+ DAYS	\$ 38,759.62	\$ 6,792.57	\$ -	33
DC FIRE DEPT AMBULANCE SVC	2025-12	PAID	01 - 30 DAYS	\$ 8,409,561.79	\$ 5,603,971.61	\$ -	8,993
DC FIRE DEPT AMBULANCE SVC	2025-12	PAID	31-90 DAYS	\$ 14,545.36	\$ 11,083.58	\$ -	12
DC FIRE DEPT AMBULANCE SVC	2025-12	PAID	91+ DAYS	\$ 15,417.70	\$ 2,014.89	\$ -	16
DC FIRE DEPT AMBULANCE SVC	2026-01	PAID	01 - 30 DAYS	\$ 2,806,819.54	\$ 2,013,016.57	\$ -	2,716
DC FIRE DEPT AMBULANCE SVC	2026-01	PAID	31-90 DAYS	\$ 24,534.10	\$ 18,665.24	\$ -	21
DC FIRE DEPT AMBULANCE SVC				\$ 104,631,780.83	\$ 78,282,280.69	\$ -	92,234
SEED SCHOOL OF WASHINGTON,DC	2024-11	PAID	01 - 30 DAYS	\$ 482.18	\$ 384.01	\$ -	12
SEED SCHOOL OF WASHINGTON,DC	2025-12	PAID	01 - 30 DAYS	\$ 229.66	\$ 174.99	\$ -	6
SEED SCHOOL OF WASHINGTON,DC				\$ 711.84	\$ 559.00	\$ -	18
PAUL PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 20,796.02	\$ 16,111.94	\$ -	643
PAUL PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 4,514.57	\$ 3,481.98	\$ -	124
PAUL PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 9,744.82	\$ 7,586.78	\$ -	295
PAUL PUBLIC CHARTER SCHOOL				\$ 35,055.41	\$ 27,180.70	\$ -	1,062
DC SCHOLARS PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 7,281.39	\$ 5,585.87	\$ -	261
DC SCHOLARS PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 2,009.62	\$ 1,531.32	\$ -	51
DC SCHOLARS PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 1,587.47	\$ 1,216.73	\$ -	46
DC SCHOLARS PUBLIC CHARTER SCHOOL				\$ 10,878.48	\$ 8,333.92	\$ -	358
D.C. DEPARTMENT OF MENTAL HEALTH	2024-10	PAID	01 - 30 DAYS	\$ 575,026.39	\$ 361,176.76	\$ 931.67	1,825
D.C. DEPARTMENT OF MENTAL HEALTH	2024-10	PAID	31-90 DAYS	\$ 5,719.04	\$ 2,658.18	\$ -	3
D.C. DEPARTMENT OF MENTAL HEALTH	2024-11	PAID	01 - 30 DAYS	\$ 1,445,227.45	\$ 896,825.41	\$ 875.00	3,398
D.C. DEPARTMENT OF MENTAL HEALTH	2024-12	PAID	01 - 30 DAYS	\$ 188,915.94	\$ 102,225.34	\$ 665.00	729
D.C. DEPARTMENT OF MENTAL HEALTH	2024-12	PAID	31-90 DAYS	\$ 1,162.81	\$ 886.06	\$ -	1
D.C. DEPARTMENT OF MENTAL HEALTH	2025-01	PAID	01 - 30 DAYS	\$ 38,431.85	\$ 13,299.46	\$ 420.00	425
D.C. DEPARTMENT OF MENTAL HEALTH	2025-02	PAID	01 - 30 DAYS	\$ 221,959.26	\$ 120,256.04	\$ -	434
D.C. DEPARTMENT OF MENTAL HEALTH	2025-03	PAID	01 - 30 DAYS	\$ 172,773.55	\$ 92,834.97	\$ -	342
D.C. DEPARTMENT OF MENTAL HEALTH	2025-03	PAID	31-90 DAYS	\$ 216.11	\$ 164.68	\$ -	1
D.C. DEPARTMENT OF MENTAL HEALTH	2025-04	PAID	01 - 30 DAYS	\$ 173,813.53	\$ 79,035.92	\$ -	193
D.C. DEPARTMENT OF MENTAL HEALTH	2025-04	PAID	31-90 DAYS	\$ 1,162.81	\$ 1,046.53	\$ -	1
D.C. DEPARTMENT OF MENTAL HEALTH	2025-05	PAID	01 - 30 DAYS	\$ 209,769.13	\$ 86,520.33	\$ -	190
D.C. DEPARTMENT OF MENTAL HEALTH	2025-05	PAID	31-90 DAYS	\$ 10,180.26	\$ 3,139.59	\$ -	3
D.C. DEPARTMENT OF MENTAL HEALTH	2025-06	PAID	01 - 30 DAYS	\$ 145,032.71	\$ 62,403.27	\$ -	102
D.C. DEPARTMENT OF MENTAL HEALTH	2025-07	PAID	01 - 30 DAYS	\$ 240,335.51	\$ 158,021.77	\$ -	185
D.C. DEPARTMENT OF MENTAL HEALTH	2025-08	PAID	01 - 30 DAYS	\$ 479,669.71	\$ 362,346.80	\$ -	404

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS
D.C. DEPARTMENT OF MENTAL HEALTH	2025-09	PAID	01 - 30 DAYS	\$ 55,606.08	\$ 20,851.27	\$ -	36
D.C. DEPARTMENT OF MENTAL HEALTH	2025-10	PAID	01 - 30 DAYS	\$ 83,254.87	\$ 63,992.74	\$ -	317
D.C. DEPARTMENT OF MENTAL HEALTH	2025-11	PAID	01 - 30 DAYS	\$ 275,297.93	\$ 209,539.67	\$ -	312
D.C. DEPARTMENT OF MENTAL HEALTH	2025-12	PAID	01 - 30 DAYS	\$ 242,497.69	\$ 180,035.96	\$ -	259
D.C. DEPARTMENT OF MENTAL HEALTH	2026-01	PAID	01 - 30 DAYS	\$ 124,953.26	\$ 98,724.99	\$ -	109
D.C. DEPARTMENT OF MENTAL HEALTH				\$ 4,691,005.89	\$ 2,915,985.74	\$ 2,891.67	9,269
ELSIE W. STOKES COMMUNITY FREEDOM	2024-11	PAID	01 - 30 DAYS	\$ 11,220.42	\$ 8,787.87	\$ -	284
ELSIE W. STOKES COMMUNITY FREEDOM	2024-12	PAID	01 - 30 DAYS	\$ 438.80	\$ 334.35	\$ -	5
ELSIE W. STOKES COMMUNITY FREEDOM	2025-12	PAID	01 - 30 DAYS	\$ 4,976.49	\$ 3,858.68	\$ -	131
ELSIE W. STOKES COMMUNITY FREEDOM				\$ 16,635.71	\$ 12,980.90	\$ -	420
KINGSMAN ACADEMY PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 5,004.64	\$ 3,813.68	\$ -	72
KINGSMAN ACADEMY PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 1,346.80	\$ 1,026.30	\$ -	21
KINGSMAN ACADEMY PUBLIC CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 49.88	\$ 38.01	\$ -	1
KINGSMAN ACADEMY PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 5,974.03	\$ 4,661.12	\$ -	123
KINGSMAN ACADEMY PUBLIC CHARTER SCHOOL				\$ 12,375.35	\$ 9,539.11	\$ -	217
EAGLE ACADEMY PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 8,043.96	\$ 6,272.39	\$ -	219
EAGLE ACADEMY PUBLIC CHARTER SCHOOL				\$ 8,043.96	\$ 6,272.39	\$ -	219
TWO RIVERS PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 18,458.39	\$ 14,329.74	\$ -	546
TWO RIVERS PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 2,001.47	\$ 1,529.99	\$ -	45
TWO RIVERS PUBLIC CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 468.04	\$ 359.81	\$ -	12
TWO RIVERS PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 12,281.27	\$ 9,390.88	\$ -	438
TWO RIVERS PUBLIC CHARTER SCHOOL				\$ 33,209.17	\$ 25,610.42	\$ -	1,041
THURGOOD MARSHALL ACADEMY PCS	2024-11	PAID	01 - 30 DAYS	\$ 3,777.45	\$ 2,924.45	\$ -	120
THURGOOD MARSHALL ACADEMY PCS	2024-12	PAID	01 - 30 DAYS	\$ 124.70	\$ 95.02	\$ -	3
THURGOOD MARSHALL ACADEMY PCS	2025-12	PAID	01 - 30 DAYS	\$ 2,927.87	\$ 2,263.04	\$ -	63
THURGOOD MARSHALL ACADEMY PCS				\$ 6,830.02	\$ 5,282.51	\$ -	186
OFFICE OF THE STATE SUPERINTENDENT	2024-10	PAID	01 - 30 DAYS	\$ 3,268,139.16	\$ 2,512,092.95	\$ -	9,762
OFFICE OF THE STATE SUPERINTENDENT	2024-11	PAID	01 - 30 DAYS	\$ 973,358.08	\$ 748,265.67	\$ -	2,838
OFFICE OF THE STATE SUPERINTENDENT	2024-12	PAID	01 - 30 DAYS	\$ 949,140.78	\$ 730,229.66	\$ -	2,814
OFFICE OF THE STATE SUPERINTENDENT	2025-01	PAID	01 - 30 DAYS	\$ 907,081.98	\$ 697,216.99	\$ -	2,641
OFFICE OF THE STATE SUPERINTENDENT	2025-02	PAID	01 - 30 DAYS	\$ 782,069.72	\$ 601,038.35	\$ -	2,319
OFFICE OF THE STATE SUPERINTENDENT	2025-03	PAID	01 - 30 DAYS	\$ 724,378.24	\$ 556,862.00	\$ -	2,140
OFFICE OF THE STATE SUPERINTENDENT	2025-04	PAID	01 - 30 DAYS	\$ 329,354.40	\$ 252,964.91	\$ -	931
OFFICE OF THE STATE SUPERINTENDENT	2025-05	PAID	01 - 30 DAYS	\$ 116,633.76	\$ 89,780.28	\$ -	336

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS
OFFICE OF THE STATE SUPERINTENDENT	2025-06	PAID	01 - 30 DAYS	\$ 40,288.00	\$ 30,929.23	\$ -	107
OFFICE OF THE STATE SUPERINTENDENT	2025-08	PAID	01 - 30 DAYS	\$ 376,289.92	\$ 288,585.74	\$ -	1,090
OFFICE OF THE STATE SUPERINTENDENT	2025-09	PAID	01 - 30 DAYS	\$ 2,205,566.56	\$ 1,694,104.50	\$ -	6,452
OFFICE OF THE STATE SUPERINTENDENT	2025-10	PAID	01 - 30 DAYS	\$ 180,893.12	\$ 140,097.27	\$ -	489
OFFICE OF THE STATE SUPERINTENDENT	2025-11	PAID	01 - 30 DAYS	\$ 1,832,701.12	\$ 1,410,731.38	\$ -	5,335
OFFICE OF THE STATE SUPERINTENDENT	2025-11	PAID	91+ DAYS	\$ 16,115.20	\$ 2,922.74	\$ -	46
OFFICE OF THE STATE SUPERINTENDENT	2025-12	PAID	01 - 30 DAYS	\$ 36,460.64	\$ 28,056.01	\$ -	101
OFFICE OF THE STATE SUPERINTENDENT	2026-01	PAID	01 - 30 DAYS	\$ 286,958.32	\$ 222,961.13	\$ -	840
OFFICE OF THE STATE SUPERINTENDENT				\$ 13,025,429.00	\$ 10,006,838.81	\$ -	38,241
GIRLS GLOBAL ACADEMY PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 1,682.94	\$ 1,341.02	\$ -	42
GIRLS GLOBAL ACADEMY PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 65.82	\$ 54.85	\$ -	2
GIRLS GLOBAL ACADEMY PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 1,508.49	\$ 1,177.09	\$ -	28
GIRLS GLOBAL ACADEMY PUBLIC CHARTER SCHOOL				\$ 3,257.25	\$ 2,572.96	\$ -	72
KIPP DC	2024-11	PAID	01 - 30 DAYS	\$ 96,107.10	\$ 74,054.67	\$ -	2,930
KIPP DC	2024-12	PAID	01 - 30 DAYS	\$ 25,259.00	\$ 19,388.22	\$ -	484
KIPP DC	2025-06	PAID	01 - 30 DAYS	\$ 4,222.76	\$ 3,232.78	\$ -	47
KIPP DC	2025-08	PAID	01 - 30 DAYS	\$ 513.85	\$ 402.49	\$ -	34
KIPP DC	2025-09	PAID	01 - 30 DAYS	\$ 30,269.04	\$ 23,314.24	\$ -	1,086
KIPP DC	2025-12	PAID	01 - 30 DAYS	\$ 53,814.25	\$ 41,498.41	\$ -	1,827
KIPP DC				\$ 210,186.00	\$ 161,890.81	\$ -	6,408
DC BILINGUAL PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 14,744.88	\$ 11,455.51	\$ -	465
DC BILINGUAL PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 1,453.20	\$ 1,116.76	\$ -	17
DC BILINGUAL PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 6,197.50	\$ 4,829.30	\$ -	271
DC BILINGUAL PUBLIC CHARTER SCHOOL				\$ 22,395.58	\$ 17,401.57	\$ -	753
DC CHILD & FAMILY SERVICES AGENCY	2024-10	PAID	01 - 30 DAYS	\$ 11,907.78	\$ 5,489.18	\$ 4,577.68	58
DC CHILD & FAMILY SERVICES AGENCY	2024-11	PAID	01 - 30 DAYS	\$ 7,349.50	\$ 5,552.20	\$ -	37
DC CHILD & FAMILY SERVICES AGENCY	2024-12	PAID	01 - 30 DAYS	\$ 11,044.60	\$ 5,984.72	\$ 2,417.38	63
DC CHILD & FAMILY SERVICES AGENCY	2025-01	PAID	01 - 30 DAYS	\$ 18,425.66	\$ 13,976.33	\$ -	99
DC CHILD & FAMILY SERVICES AGENCY	2025-02	PAID	01 - 30 DAYS	\$ 10,197.50	\$ 7,690.22	\$ -	59
DC CHILD & FAMILY SERVICES AGENCY	2025-03	PAID	01 - 30 DAYS	\$ 5,859.68	\$ 4,433.02	\$ -	35
DC CHILD & FAMILY SERVICES AGENCY	2025-04	PAID	01 - 30 DAYS	\$ 14,991.35	\$ 9,477.65	\$ 1,725.70	108
DC CHILD & FAMILY SERVICES AGENCY	2025-05	PAID	01 - 30 DAYS	\$ 6,630.00	\$ 4,189.41	\$ 1,090.00	33
DC CHILD & FAMILY SERVICES AGENCY	2025-06	PAID	01 - 30 DAYS	\$ 4,430.25	\$ 3,326.19	\$ -	81
DC CHILD & FAMILY SERVICES AGENCY	2025-07	PAID	01 - 30 DAYS	\$ 15,086.34	\$ 9,074.17	\$ 2,080.78	78

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS
DC CHILD & FAMILY SERVICES AGENCY	2025-08	PAID	01 - 30 DAYS	\$ 4,021.81	\$ 3,064.15	\$ -	23
DC CHILD & FAMILY SERVICES AGENCY	2025-09	PAID	01 - 30 DAYS	\$ 10,835.19	\$ 8,191.08	\$ -	84
DC CHILD & FAMILY SERVICES AGENCY	2025-10	PAID	01 - 30 DAYS	\$ 17,568.22	\$ 11,571.43	\$ 2,186.89	99
DC CHILD & FAMILY SERVICES AGENCY	2025-11	PAID	01 - 30 DAYS	\$ 763.90	\$ 415.98	\$ 218.00	4
DC CHILD & FAMILY SERVICES AGENCY	2025-12	PAID	01 - 30 DAYS	\$ 12,455.17	\$ 7,283.85	\$ 2,843.67	86
DC CHILD & FAMILY SERVICES AGENCY				\$ 151,566.95	\$ 99,719.58	\$ 17,140.10	947
MONUMENT ACADEMY PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 3,123.31	\$ 2,399.66	\$ -	108
MONUMENT ACADEMY PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 175.44	\$ 137.86	\$ -	6
MONUMENT ACADEMY PUBLIC CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 58.48	\$ 44.56	\$ -	2
MONUMENT ACADEMY PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 2,089.08	\$ 1,673.31	\$ -	63
MONUMENT ACADEMY PUBLIC CHARTER SCHOOL				\$ 5,446.31	\$ 4,255.39	\$ -	179
THE CHILDRENS GUILD, LTD.	2024-11	PAID	01 - 30 DAYS	\$ 6,484.61	\$ 5,001.80	\$ -	243
THE CHILDRENS GUILD, LTD.	2024-12	PAID	01 - 30 DAYS	\$ 74.82	\$ 57.00	\$ -	3
THE CHILDRENS GUILD, LTD.	2025-06	PAID	01 - 30 DAYS	\$ 87.48	\$ 68.74	\$ -	6
THE CHILDRENS GUILD, LTD.				\$ 6,646.91	\$ 5,127.54	\$ -	252
EARLY CHILDHOOD ACADEMY PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 9,714.35	\$ 7,562.45	\$ -	346
EARLY CHILDHOOD ACADEMY PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 372.07	\$ 289.76	\$ -	8
EARLY CHILDHOOD ACADEMY PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 1,909.24	\$ 1,503.85	\$ -	51
EARLY CHILDHOOD ACADEMY PUBLIC CHARTER SCHOOL				\$ 11,995.66	\$ 9,356.06	\$ -	405
OFFICE OF THE STATE SUPERINTENDENT	2024-10	PAID	01 - 30 DAYS	\$ 20,610.23	\$ 15,976.19	\$ -	601
OFFICE OF THE STATE SUPERINTENDENT	2024-11	PAID	01 - 30 DAYS	\$ 8,029.62	\$ 6,181.90	\$ -	224
OFFICE OF THE STATE SUPERINTENDENT	2025-05	PAID	01 - 30 DAYS	\$ 29.24	\$ 22.28	\$ -	2
OFFICE OF THE STATE SUPERINTENDENT	2025-07	PAID	01 - 30 DAYS	\$ 4,169.89	\$ 3,213.25	\$ -	129
OFFICE OF THE STATE SUPERINTENDENT	2025-08	PAID	01 - 30 DAYS	\$ 156,056.73	\$ 119,897.18	\$ -	4,405
OFFICE OF THE STATE SUPERINTENDENT	2025-09	PAID	01 - 30 DAYS	\$ 60,531.92	\$ 47,177.48	\$ -	1,619
OFFICE OF THE STATE SUPERINTENDENT	2025-10	PAID	01 - 30 DAYS	\$ 41,828.69	\$ 32,554.99	\$ -	1,059
OFFICE OF THE STATE SUPERINTENDENT	2025-12	PAID	01 - 30 DAYS	\$ 37,357.98	\$ 28,881.34	\$ -	1,020
OFFICE OF THE STATE SUPERINTENDENT				\$ 328,614.30	\$ 253,904.61	\$ -	9,059
MERIDIAN PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 8,179.13	\$ 6,282.60	\$ -	306
MERIDIAN PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 394.90	\$ 300.94	\$ -	11
MERIDIAN PUBLIC CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 685.02	\$ 530.28	\$ -	17
MERIDIAN PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 12,112.58	\$ 9,293.46	\$ -	352
MERIDIAN PUBLIC CHARTER SCHOOL				\$ 21,371.63	\$ 16,407.28	\$ -	686
EUPHEMIA L HAYNES PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 24,040.81	\$ 18,882.07	\$ -	744

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS
EUPHEMIA L HAYNES PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 2,609.45	\$ 2,018.32	\$ -	70
EUPHEMIA L HAYNES PUBLIC CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 2,166.27	\$ 1,700.66	\$ -	81
EUPHEMIA L HAYNES PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 120.00	\$ 97.16	\$ -	3
EUPHEMIA L HAYNES PUBLIC CHARTER SCHOOL				\$ 28,936.53	\$ 22,698.21	\$ -	898
INGENUITY PREP PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 6,513.98	\$ 4,963.60	\$ -	145
INGENUITY PREP PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 852.93	\$ 652.02	\$ -	18
INGENUITY PREP PUBLIC CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 229.23	\$ 174.66	\$ -	9
INGENUITY PREP PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 8,646.26	\$ 6,655.13	\$ -	322
INGENUITY PREP PUBLIC CHARTER SCHOOL				\$ 16,242.40	\$ 12,445.41	\$ -	494
CESAR CHAVEZ PCS FOR PUBLIC POLICY	2024-11	PAID	01 - 30 DAYS	\$ 5,150.84	\$ 3,990.90	\$ -	155
CESAR CHAVEZ PCS FOR PUBLIC POLICY	2025-06	PAID	01 - 30 DAYS	\$ 58.32	\$ 48.60	\$ -	2
CESAR CHAVEZ PCS FOR PUBLIC POLICY	2025-12	PAID	01 - 30 DAYS	\$ 787.32	\$ 606.16	\$ -	33
CESAR CHAVEZ PCS FOR PUBLIC POLICY				\$ 5,996.48	\$ 4,645.66	\$ -	190
HARMONY DC PUBLIC CHARTER SCHOOLS	2024-11	PAID	01 - 30 DAYS	\$ 8,938.99	\$ 6,846.78	\$ -	249
HARMONY DC PUBLIC CHARTER SCHOOLS	2024-12	PAID	01 - 30 DAYS	\$ 1,044.68	\$ 802.28	\$ -	30
HARMONY DC PUBLIC CHARTER SCHOOLS	2025-12	PAID	01 - 30 DAYS	\$ 10,632.35	\$ 8,121.48	\$ -	260
HARMONY DC PUBLIC CHARTER SCHOOLS				\$ 20,616.02	\$ 15,770.54	\$ -	539
WASHINGTON LEADERSHIP ACADEMY PCS	2024-12	PAID	01 - 30 DAYS	\$ 5,015.56	\$ 3,929.07	\$ -	146
WASHINGTON LEADERSHIP ACADEMY PCS	2025-06	PAID	01 - 30 DAYS	\$ 112.23	\$ 91.74	\$ -	4
WASHINGTON LEADERSHIP ACADEMY PCS	2025-12	PAID	01 - 30 DAYS	\$ 4,645.30	\$ 3,686.85	\$ -	184
WASHINGTON LEADERSHIP ACADEMY PCS				\$ 9,773.09	\$ 7,707.66	\$ -	334
FRIENDSHIP PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 25,136.81	\$ 19,430.06	\$ -	784
FRIENDSHIP PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 8,390.04	\$ 6,493.14	\$ -	107
FRIENDSHIP PUBLIC CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 686.00	\$ 533.15	\$ -	30
FRIENDSHIP PUBLIC CHARTER SCHOOL	2025-11	PAID	01 - 30 DAYS	\$ 14.58	\$ 11.11	\$ -	1
FRIENDSHIP PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 46,561.77	\$ 35,962.40	\$ -	1,774
FRIENDSHIP PUBLIC CHARTER SCHOOL				\$ 80,789.20	\$ 62,429.86	\$ -	2,696
ROCKETSHIP EDUCATION	2024-11	PAID	01 - 30 DAYS	\$ 13,037.50	\$ 9,997.21	\$ -	511
ROCKETSHIP EDUCATION	2024-12	PAID	01 - 30 DAYS	\$ 8,728.19	\$ 6,690.38	\$ -	305
ROCKETSHIP EDUCATION	2025-12	PAID	01 - 30 DAYS	\$ 25,541.72	\$ 19,567.99	\$ -	1,067
ROCKETSHIP EDUCATION				\$ 47,307.41	\$ 36,255.58	\$ -	1,883
DC PREPARATORY ACADEMY	2024-11	PAID	01 - 30 DAYS	\$ 12,054.01	\$ 9,277.11	\$ -	413
DC PREPARATORY ACADEMY	2024-12	PAID	01 - 30 DAYS	\$ 1,649.99	\$ 1,260.38	\$ -	53
DC PREPARATORY ACADEMY	2025-06	PAID	01 - 30 DAYS	\$ 160.50	\$ 123.33	\$ -	9

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS
DC PREPARATORY ACADEMY	2025-12	PAID	01 - 30 DAYS	\$ 9,300.93	\$ 7,205.85	\$ -	325
DC PREPARATORY ACADEMY				\$ 23,165.43	\$ 17,866.67	\$ -	800
BRIDGES PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 20,119.11	\$ 15,527.07	\$ -	667
BRIDGES PUBLIC CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 1,730.18	\$ 1,344.47	\$ -	56
BRIDGES PUBLIC CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 131.64	\$ 100.32	\$ -	3
BRIDGES PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 14,106.63	\$ 11,063.44	\$ -	427
BRIDGES PUBLIC CHARTER SCHOOL				\$ 36,087.56	\$ 28,035.30	\$ -	1,153
OFFICE OF THE STATE SUPERINTENDENT	2024-10	PAID	01 - 30 DAYS	\$ 34,159.68	\$ 34,159.68	\$ -	236
OFFICE OF THE STATE SUPERINTENDENT	2024-11	PAID	01 - 30 DAYS	\$ 440.00	\$ 440.00	\$ -	4
OFFICE OF THE STATE SUPERINTENDENT	2024-12	PAID	01 - 30 DAYS	\$ 17,033.54	\$ 16,908.54	\$ -	117
OFFICE OF THE STATE SUPERINTENDENT	2025-01	PAID	01 - 30 DAYS	\$ 12,782.50	\$ 12,782.50	\$ -	93
OFFICE OF THE STATE SUPERINTENDENT	2025-02	PAID	01 - 30 DAYS	\$ 12,042.50	\$ 12,042.50	\$ -	86
OFFICE OF THE STATE SUPERINTENDENT	2025-02	PAID	91+ DAYS	\$ 862.50	\$ 862.50	\$ -	6
OFFICE OF THE STATE SUPERINTENDENT	2025-03	PAID	01 - 30 DAYS	\$ 11,772.50	\$ 11,772.50	\$ -	85
OFFICE OF THE STATE SUPERINTENDENT	2025-04	PAID	01 - 30 DAYS	\$ 17,099.94	\$ 16,849.94	\$ -	124
OFFICE OF THE STATE SUPERINTENDENT	2025-05	PAID	01 - 30 DAYS	\$ 16,938.72	\$ 16,688.72	\$ -	123
OFFICE OF THE STATE SUPERINTENDENT	2025-06	PAID	01 - 30 DAYS	\$ 14,974.76	\$ 14,662.26	\$ -	108
OFFICE OF THE STATE SUPERINTENDENT	2025-07	PAID	01 - 30 DAYS	\$ 28,449.76	\$ 26,887.26	\$ -	209
OFFICE OF THE STATE SUPERINTENDENT	2025-09	PAID	01 - 30 DAYS	\$ 11,330.46	\$ 11,267.96	\$ -	85
OFFICE OF THE STATE SUPERINTENDENT	2025-10	PAID	01 - 30 DAYS	\$ 24,601.38	\$ 24,538.88	\$ -	181
OFFICE OF THE STATE SUPERINTENDENT	2025-12	PAID	01 - 30 DAYS	\$ 11,220.40	\$ 11,220.40	\$ -	83
OFFICE OF THE STATE SUPERINTENDENT				\$ 213,708.64	\$ 211,083.64	\$ -	1,540
ST COLETTA SPECL ED CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 30,812.30	\$ 23,478.69	\$ -	1,099
ST COLETTA SPECL ED CHARTER SCHOOL	2024-12	PAID	01 - 30 DAYS	\$ 14,141.61	\$ 10,793.56	\$ -	485
ST COLETTA SPECL ED CHARTER SCHOOL	2025-06	PAID	01 - 30 DAYS	\$ 21,656.71	\$ 16,576.76	\$ -	809
ST COLETTA SPECL ED CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 133,019.99	\$ 102,093.21	\$ -	4,993
ST COLETTA SPECL ED CHARTER SCHOOL				\$ 199,630.61	\$ 152,942.22	\$ -	7,386
APPLETREE EARLY LEARNING PUBLIC CHARTER SCHOOL	2024-11	PAID	01 - 30 DAYS	\$ 1,599.58	\$ 1,224.80	\$ -	51
APPLETREE EARLY LEARNING PUBLIC CHARTER SCHOOL	2025-12	PAID	01 - 30 DAYS	\$ 1,272.33	\$ 969.55	\$ -	40
APPLETREE EARLY LEARNING PUBLIC CHARTER SCHOOL				\$ 2,871.91	\$ 2,194.35	\$ -	91
DC DEPT OF BEHAVIORAL HEALTH	2024-10	PAID	01 - 30 DAYS	\$ 3,659.80	\$ 1,959.45	\$ 391.11	30
DC DEPT OF BEHAVIORAL HEALTH	2024-11	PAID	01 - 30 DAYS	\$ 6,718.06	\$ 4,591.16	\$ 651.85	59
DC DEPT OF BEHAVIORAL HEALTH	2024-12	PAID	01 - 30 DAYS	\$ 3,436.84	\$ 1,537.87	\$ 248.59	25
DC DEPT OF BEHAVIORAL HEALTH				\$ 13,814.70	\$ 8,088.48	\$ 1,291.55	114

AGENCY/PROVIDER NAME	MONTH	STATUS	PROCESS SPAN	BILLED	FFS_PAID	MCO_PAID	# of CLAIMS

\$ 143,536,598.28 \$ 103,335,418.64 \$ 21,323.32 233,776

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030329900 Total

030472754	SEED SCHOOL OF WASHINGTON,DC	2025-12	DENIED

030472754 Total

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033939300	D.C. DEPARTMENT OF MENTAL HEALTH	2026-01	DENIED
033939300	D.C. DEPARTMENT OF MENTAL HEALTH	2026-01	DENIED
033939300	D.C. DEPARTMENT OF MENTAL HEALTH	2026-01	DENIED
033939300	D.C. DEPARTMENT OF MENTAL HEALTH	2026-01	DENIED
033939300	D.C. DEPARTMENT OF MENTAL HEALTH	2026-01	DENIED
033939300 Total			
035648400	ELSIE W. STOKES COMMUNITY FREEDOM	2025-12	DENIED
035648400	ELSIE W. STOKES COMMUNITY FREEDOM	2025-12	DENIED
035648400 Total			
036143492	KINGSMAN ACADEMY PUBLIC CHARTER SCHOOL	2025-12	DENIED
036143492	KINGSMAN ACADEMY PUBLIC CHARTER SCHOOL	2025-12	DENIED
036143492	KINGSMAN ACADEMY PUBLIC CHARTER SCHOOL	2025-12	DENIED
036143492 Total			
036679600	TWO RIVERS PUBLIC CHARTER SCHOOL	2025-07	DENIED
036679600	TWO RIVERS PUBLIC CHARTER SCHOOL	2025-07	DENIED
036679600	TWO RIVERS PUBLIC CHARTER SCHOOL	2025-12	DENIED
036679600	TWO RIVERS PUBLIC CHARTER SCHOOL	2025-12	DENIED
036679600 Total			
038633200	THURGOOD MARSHALL ACADEMY PCS	2025-12	DENIED
038633200	THURGOOD MARSHALL ACADEMY PCS	2025-12	DENIED
038633200 Total			
041240500	OFFICE OF THE STATE SUPERINTENDENT	2024-10	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2024-10	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2024-11	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2024-12	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-01	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-01	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-01	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-02	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-02	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-03	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-04	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-04	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-06	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-06	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-09	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-09	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-09	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-09	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-09	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-09	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-10	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-10	DENIED

041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-10	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-11	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-11	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-11	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-11	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2025-12	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2026-01	DENIED
041240500	OFFICE OF THE STATE SUPERINTENDENT	2026-01	DENIED
041240500 Total			
042487502	GIRLS GLOBAL ACADEMY PUBLIC CHARTER	2025-12	DENIED
042487502	GIRLS GLOBAL ACADEMY PUBLIC CHARTER	2025-12	DENIED
042487502 Total			
045265500	KIPP DC	2025-06	DENIED
045265500	KIPP DC	2025-06	DENIED
045265500	KIPP DC	2025-08	DENIED
045265500	KIPP DC	2025-08	DENIED
045265500	KIPP DC	2025-08	DENIED
045265500	KIPP DC	2025-09	DENIED
045265500	KIPP DC	2025-09	DENIED
045265500	KIPP DC	2025-09	DENIED
045265500	KIPP DC	2025-09	DENIED
045265500	KIPP DC	2025-11	DENIED
045265500	KIPP DC	2025-11	DENIED
045265500	KIPP DC	2025-11	DENIED
045265500	KIPP DC	2025-11	DENIED
045265500	KIPP DC	2025-11	DENIED
045265500	KIPP DC	2025-11	DENIED
045265500	KIPP DC	2025-12	DENIED
045265500	KIPP DC	2025-12	DENIED
045265500	KIPP DC	2025-12	DENIED
045265500	KIPP DC	2025-12	DENIED
045265500	KIPP DC	2025-12	DENIED
045265500 Total			
045520600	DC BILINGUAL PUBLIC CHARTER SCHOOL	2025-12	DENIED
045520600	DC BILINGUAL PUBLIC CHARTER SCHOOL	2025-12	DENIED
045520600 Total			
047353700	DC CHILD & FAMILY SERVICES AGENCY	2024-10	DENIED
047353700	DC CHILD & FAMILY SERVICES AGENCY	2024-10	DENIED
047353700	DC CHILD & FAMILY SERVICES AGENCY	2024-10	DENIED
047353700	DC CHILD & FAMILY SERVICES AGENCY	2024-10	DENIED
047353700	DC CHILD & FAMILY SERVICES AGENCY	2024-10	DENIED
047353700	DC CHILD & FAMILY SERVICES AGENCY	2024-10	DENIED
047353700	DC CHILD & FAMILY SERVICES AGENCY	2024-11	DENIED
047353700	DC CHILD & FAMILY SERVICES AGENCY	2024-11	DENIED

[illegible]

047353700 Total

052048954	MONUMENT ACADEMY PUBLIC CHARTER SCHOOL	2025-12	DENIED
052048954	MONUMENT ACADEMY PUBLIC CHARTER SCHOOL	2025-12	DENIED

052048954 Total

055207400	THE CHILDRENS GUILD, LTD.	2024-11	DENIED
055207400	THE CHILDRENS GUILD, LTD.	2024-11	DENIED
055207400	THE CHILDRENS GUILD, LTD.	2024-11	DENIED
055207400	THE CHILDRENS GUILD, LTD.	2025-06	DENIED
055207400	THE CHILDRENS GUILD, LTD.	2025-06	DENIED
055207400	THE CHILDRENS GUILD, LTD.	2025-06	DENIED

055207400 Total

061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-08	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-08	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-09	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-10	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-10	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-10	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-10	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-10	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-12	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-12	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-12	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-12	DENIED
061748200	OFFICE OF THE STATE SUPERINTENDENT	2025-12	DENIED

061748200 Total

063352800	MERIDIAN PUBLIC CHARTER SCHOOL	2025-12	DENIED
063352800	MERIDIAN PUBLIC CHARTER SCHOOL	2025-12	DENIED

063352800 Total

063473495	EUPHEMIA L HAYNES PUBLIC CHARTER SCHOOL	2024-11	DENIED
063473495	EUPHEMIA L HAYNES PUBLIC CHARTER SCHOOL	2024-11	DENIED
063473495	EUPHEMIA L HAYNES PUBLIC CHARTER SCHOOL	2024-11	DENIED

063473495 Total

065995481	INGENUITY PREP PUBLIC CHARTER SCHOOL	2025-06	DENIED
065995481	INGENUITY PREP PUBLIC CHARTER SCHOOL	2025-06	DENIED
065995481	INGENUITY PREP PUBLIC CHARTER SCHOOL	2025-12	DENIED
065995481	INGENUITY PREP PUBLIC CHARTER SCHOOL	2025-12	DENIED

065995481 Total

073813100	CESAR CHAVEZ PCS FOR PUBLIC POLICY	2024-12	DENIED
073813100	CESAR CHAVEZ PCS FOR PUBLIC POLICY	2025-12	DENIED
073813100	CESAR CHAVEZ PCS FOR PUBLIC POLICY	2025-12	DENIED

073813100 Total

073985228	HARMONY DC PUBLIC CHARTER SCHOOLS	2025-12	DENIED
073985228	HARMONY DC PUBLIC CHARTER SCHOOLS	2025-12	DENIED

073985228 Total

074618293	WASHINGTON LEADERSHIP ACADEMY PCS	2025-12	DENIED
074618293 Total			
075270300	FRIENDSHIP PUBLIC CHARTER SCHOOL	2025-12	DENIED
075270300	FRIENDSHIP PUBLIC CHARTER SCHOOL	2025-12	DENIED
075270300 Total			
077050107	ROCKETSHIP EDUCATION	2025-12	DENIED
077050107	ROCKETSHIP EDUCATION	2025-12	DENIED
077050107	ROCKETSHIP EDUCATION	2025-12	DENIED
077050107 Total			
077288941	DC PREPARATORY ACADEMY	2024-11	DENIED
077288941	DC PREPARATORY ACADEMY	2024-11	DENIED
077288941	DC PREPARATORY ACADEMY	2024-11	DENIED
077288941	DC PREPARATORY ACADEMY	2025-06	DENIED
077288941	DC PREPARATORY ACADEMY	2025-06	DENIED
077288941	DC PREPARATORY ACADEMY	2025-06	DENIED
077288941	DC PREPARATORY ACADEMY	2025-12	DENIED
077288941	DC PREPARATORY ACADEMY	2025-12	DENIED
077288941 Total			
080033279	BRIDGES PUBLIC CHARTER SCHOOL	2025-12	DENIED
080033279	BRIDGES PUBLIC CHARTER SCHOOL	2025-12	DENIED
080033279 Total			
085560600	OFFICE OF THE STATE SUPERINTENDENT	2024-10	DENIED
085560600	OFFICE OF THE STATE SUPERINTENDENT	2024-10	DENIED
085560600	OFFICE OF THE STATE SUPERINTENDENT	2024-10	DENIED
085560600	OFFICE OF THE STATE SUPERINTENDENT	2025-04	DENIED
085560600	OFFICE OF THE STATE SUPERINTENDENT	2025-07	DENIED
085560600	OFFICE OF THE STATE SUPERINTENDENT	2025-07	DENIED
085560600 Total			
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2024-12	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2024-12	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2024-12	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2025-06	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2025-06	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2025-06	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2025-06	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2025-12	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2025-12	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2025-12	DENIED
094560500	ST COLETTA SPECL ED CHARTER SCHOOL	2025-12	DENIED
094560500 Total			
096933009	APPLETREE EARLY LEARNING PUBLIC CHARTER	2024-11	DENIED
096933009	APPLETREE EARLY LEARNING PUBLIC CHARTER	2024-11	DENIED
096933009	APPLETREE EARLY LEARNING PUBLIC CHARTER	2025-12	DENIED

[illegible]

Grand Total

PROCESS SPAN	EXCP_CODE	EXCP_DESC	BILLED	TALLY
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 167.95	5
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 167.95	5
				10
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 175.32	8
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 175.32	8
				16
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 1,031.68	7
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 2,982.60	2
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 51,985.82	243
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$ 431.29	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 40,166.13	189
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 637.44	8
31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 637.44	8
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 1,586.48	6
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 1,586.48	6
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 1,586.48	6
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 1,073.28	9
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 6,659.02	13
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 5,906.57	31
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 9,569.36	33
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 1,803.00	6
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 551.62	5
01 - 30 DAYS	0757	TPL-IND ON CLM-NO RES ON FILE	\$ 474.52	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 474.52	2
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$ 396.80	5
01 - 30 DAYS	2296	SBHS REQ REFER PROV NPI - SUSP	\$ 396.80	5
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$ 18,301.54	97
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 90,188.49	470
01 - 30 DAYS	5318	CALC ALLOW CHRG LES TPL IS ZER	\$ 474.52	2
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$ 1,496.14	8
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 48,806.21	320
01 - 30 DAYS	8504	NCCI HIST CLM FOUND-ADJUST	\$ 158.72	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 119.52	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 317.44	2
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 2,984.48	14
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$ 2,381.54	23
01 - 30 DAYS	2296	SBHS REQ REFER PROV NPI - SUSP	\$ 2,381.54	23
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$ 48,478.47	250
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 132,672.57	604
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$ 237.26	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 117,558.15	588
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 81.82	1

01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	3,398.74	24
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$	1,063.66	8
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	1,389.06	11
01 - 30 DAYS	2296	SBHS REQ REFER PROV NPI - SUSP	\$	1,389.06	11
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	37,754.99	221
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	1,204.94	3
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	59,936.07	368
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	118.63	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	70,612.39	464
01 - 30 DAYS	8504	NCCI HIST CLM FOUND-ADJUST	\$	597.60	5
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	585.45	2
31-90 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	585.45	2
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	994.22	9
01 - 30 DAYS	2296	SBHS REQ REFER PROV NPI - SUSP	\$	994.22	9
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	16,204.44	8
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	8,555.00	4
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	2,906.58	10
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	25,955.02	18
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	597.60	4
31-90 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	2,002.68	7
31-90 DAYS	5257	BENFC ON REVIEW NOT SUSP DUPE	\$	1,405.08	3
31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	597.60	4
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$	327.28	2
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	13,389.14	87
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	6,021.02	26
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	1,299.01	7
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	4,530.73	17
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	6,750.46	47
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	163.64	1
01 - 30 DAYS	0116	ADD-ON PROC W/O PRIMARY PROC	\$	19,248.75	5
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	470.31	2
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$	245.46	3
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	31,711.54	178
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	38,418.17	222
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	1,785.60	15
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	63,267.98	292
01 - 30 DAYS	8504	NCCI HIST CLM FOUND-ADJUST	\$	317.44	3
					5,097
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	58,047.04	75
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$	21,732.63	18
01 - 30 DAYS	0117	INVALID 1ST PROC CODE MODIFIER	\$	2,623.00	2
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	75,852.63	76
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$	1,578.75	2
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	63,038.92	60

01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 22,277.89	18
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 73,286.72	80
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 3,128.25	3
01 - 30 DAYS	0750	TPL-FOR BENFC-RESUB W/TPL EOB	\$ 1,574.25	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 495,801.79	583
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 3,000.00	2
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 11,758.19	10
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 306,238.87	252
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 12,423.38	135
01 - 30 DAYS	2200	WEB CLAIM WITH ATTACHMENT	\$ 1,250.80	2
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 5,279.73	4
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 18,048.63	22
01 - 30 DAYS	5217	UNABLE TO PRICE MODIFIER	\$ 2,623.00	2
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 48,201.62	46
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 181,950.21	147
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 51,265.56	42
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 70,845.57	68
01 - 30 DAYS	5318	CALC ALLOW CHRG LES TPL IS ZER	\$ 1,385.80	3
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 46,588.53	50
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 5,166.21	6
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 46,588.53	50
31-90 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 573.75	5
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 59,604.26	74
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 45,215.54	40
01 - 30 DAYS	0118	MCARE ALLOWED AMT CNFL	\$ 58.50	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 45,194.09	44
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 20,766.63	22
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 9,145.17	8
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 40,954.80	45
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 322,394.61	382
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 4,598.62	4
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 137,030.17	117
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 7,496.25	74
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 16,261.93	20
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 39,116.38	44
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 86,684.57	71
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 21,698.59	18
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 44,340.29	42
31-90 DAYS	0118	MCARE ALLOWED AMT CNFL	\$ 1,533.75	2
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 7,808.16	8
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 47,609.01	48
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 10,422.46	10
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 55,417.17	56
31-90 DAYS	1211	XOVER DEDUCT EXCDS ALLOW MAX	\$ 1,302.50	2

31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 7,017.07	6
31-90 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 173.25	1
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 7,808.16	8
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 78,474.87	97
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 33,996.07	28
01 - 30 DAYS	0118	MCARE ALLOWED AMT CNFL	\$ 3,193.50	4
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 37,262.63	35
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 34,549.13	32
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 26,092.97	22
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 74,765.10	73
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 1,549.50	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 410,999.69	447
01 - 30 DAYS	1211	XOVER DEDUCT EXCDS ALLOW MAX	\$ 92.25	2
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 6,177.75	6
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 235,250.63	198
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 6,397.88	67
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 3,930.79	4
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 25,980.07	30
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 25,139.48	26
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 107,085.76	85
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 78,480.48	68
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 36,822.26	32
01 - 30 DAYS	5318	CALC ALLOW CHRG LES TPL IS ZER	\$ 1,612.50	2
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 1,558.50	2
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 22,391.64	20
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 23,950.14	22
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 2,384.41	2
31-90 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 22.50	1
31-90 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 1,558.50	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 9,469.65	13
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 53,525.92	46
01 - 30 DAYS	0117	INVALID 1ST PROC CODE MODIFIER	\$ 2,486.53	2
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 37,843.42	36
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 9,389.25	12
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 31,867.61	30
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 12,058.52	10
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 59,531.05	66
01 - 30 DAYS	0332	DIAG/RELATED DIAG CODE MISSING	\$ 1,565.25	2
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 1,565.25	2
01 - 30 DAYS	0750	TPL-FOR BENFC-RESUB W/TPL EOB	\$ 1,587.75	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 369,644.55	403
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 4,632.66	4
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 231,851.38	197
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 17,522.50	88

01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 18,901.54	24
01 - 30 DAYS	5217	UNABLE TO PRICE MODIFIER	\$ 2,486.53	2
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 37,279.41	36
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 101,303.51	83
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 81,244.82	72
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 56,130.76	50
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 6,263.45	6
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 46,964.16	49
31-90 DAYS	0221	BENFC NAME MISMATCH	\$ 1,612.50	2
31-90 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 3,128.25	4
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 11,411.81	10
31-90 DAYS	0412	SERV PROV NOT ON FILE	\$ 3,128.25	4
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 3,128.25	4
31-90 DAYS	1122	PROC CODE/MODIFIER MATCH	\$ 57,968.36	61
31-90 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 477.00	4
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 6,263.45	6
31-90 DAYS	5671	INVALID REND/ATTEN NPI	\$ 3,128.25	4
01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$ 65.25	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 1,894.91	4
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 34,949.50	29
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 18,328.33	16
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 12,730.52	14
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 29,247.30	26
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 36,925.37	30
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 56,319.85	46
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 65.25	1
01 - 30 DAYS	0723	MCARE DED+COINS>ALWD AMT	\$ 1,668.75	2
01 - 30 DAYS	1122	PROC CODE/MODIFIER MATCH	\$ 399,868.55	359
01 - 30 DAYS	1211	XOVER DEDUCT EXCDS ALLOW MAX	\$ 90.00	1
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 7,970.81	6
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 336,196.25	279
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 12,582.77	33
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 20,278.04	22
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 52,423.85	42
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 189,262.41	152
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 88,431.51	74
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 33,348.63	28
31-90 DAYS	0103	POSSIBLE CONFLICT CLAIM	\$ 2,282.29	2
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 8,868.74	8
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 24,642.92	23
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 6,779.44	6
31-90 DAYS	1122	PROC CODE/MODIFIER MATCH	\$ 33,511.66	31
31-90 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 339.75	3
31-90 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 7,323.74	6

31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 1,545.00	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 1,984.37	5
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 55,524.15	47
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 62,543.84	56
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 47,551.79	42
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 21,256.07	16
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 65,149.30	56
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 1,671.00	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 333,363.42	291
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 2,486.53	2
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 243,513.10	204
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 591.75	6
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 2,316.33	2
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 32,493.00	32
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 29,805.56	24
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 94,629.01	76
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 54,706.20	46
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 48,014.33	41
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 61,348.77	50
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 4,564.58	4
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 61,348.77	50
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 6,724.63	7
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 53,037.31	45
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 39,901.56	36
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 3,639.13	4
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 54,469.42	48
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 46,001.08	37
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 84,379.73	78
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 1,689.00	4
01 - 30 DAYS	0750	TPL-FOR BENFC-RESUB W/TPL EOB	\$ 3,191.25	4
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 439,074.61	394
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 11,133.92	12
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 334,729.63	290
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 4,457.40	14
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 64,878.73	72
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 43,476.36	36
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 153,368.73	123
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 50,249.44	41
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 49,846.89	42
31-90 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 63.00	1
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 9,435.82	8
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 73,134.66	60
31-90 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 1,563.00	2
31-90 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 1,500.00	1

31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 11,922.36	10
31-90 DAYS	0412	SERV PROV NOT ON FILE	\$ 1,500.00	1
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 1,500.00	1
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 84,133.48	70
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 4,700.74	4
31-90 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 1,563.00	2
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 9,435.82	8
31-90 DAYS	5671	INVALID REND/ATTEN NPI	\$ 1,500.00	1
91+ DAYS	0101	EXACT DUPLICATE CLAIM	\$ 2,930.00	4
91+ DAYS	1122	PROC CODE/MODIFER MATCH	\$ 2,930.00	4
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 18,360.44	16
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 20,919.11	23
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 5,685.76	6
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 22,195.95	20
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 35,153.68	28
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 56,058.86	52
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 1,569.75	3
01 - 30 DAYS	0750	TPL-FOR BENFC-RESUB W/TPL EOB	\$ 5,056.00	6
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 232,606.02	204
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 4,973.37	4
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 191,899.07	163
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 5,817.01	7
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 18,555.94	22
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 23,586.24	20
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 108,832.75	87
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 22,038.99	18
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 34,787.54	30
01 - 30 DAYS	5318	CALC ALLOW CHRG LES TPL IS ZER	\$ 22.50	1
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 53,030.37	44
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 53,030.37	44
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 2,350.37	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 3,321.53	5
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 54,025.09	46
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 45,123.13	42
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 3,783.51	4
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 32,124.24	28
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 24,662.30	20
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 54,943.26	49
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 6,153.00	6
01 - 30 DAYS	0750	TPL-FOR BENFC-RESUB W/TPL EOB	\$ 1,889.13	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 313,824.70	270
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 5,965.38	6
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 213,996.31	182
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 3,783.51	4

01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 2,418.45	2
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 29,166.15	31
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 33,179.68	27
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 108,711.83	88
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 33,893.58	27
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 44,964.01	38
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 2,350.37	2
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 21,664.55	18
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 4,530.54	4
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 24,014.92	20
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 2,350.37	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 1,727.55	5
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 57,772.34	48
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 48,559.39	46
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 3,649.63	4
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 67,497.63	58
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 51,743.05	42
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 56,544.99	56
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 17,595.00	17
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 391,135.03	346
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 4,564.58	3
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 2,384.41	2
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 261,183.81	220
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 4,041.14	10
01 - 30 DAYS	2200	WEB CLAIM WITH ATTACHMENT	\$ 8,878.75	11
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 8,413.64	6
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 58,936.62	62
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 28,830.63	24
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 125,919.77	101
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 28,920.21	24
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 42,436.78	36
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 4,496.50	4
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 14,812.21	12
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 6,317.46	6
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 19,308.71	16
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 4,137.29	4
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 4,496.50	4
01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$ 128.25	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 1,752.63	2
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 48,812.76	40
01 - 30 DAYS	0117	INVALID 1ST PROC CODE MODIFIER	\$ 2,248.25	2
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 28,034.55	24
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 13,192.40	14
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 31,505.18	28

01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 21,902.83	18
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 57,732.90	50
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 7,763.25	8
01 - 30 DAYS	0750	TPL-FOR BENFC-RESUB W/TPL EOB	\$ 1,894.38	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 327,694.94	282
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 4,496.50	4
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 211,688.75	176
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 15,105.15	16
01 - 30 DAYS	2200	WEB CLAIM WITH ATTACHMENT	\$ 1,500.00	1
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 3,370.54	4
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 26,959.57	27
01 - 30 DAYS	5217	UNABLE TO PRICE MODIFIER	\$ 2,248.25	2
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 25,228.30	22
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 127,394.02	104
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 34,302.37	28
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 37,470.07	32
01 - 30 DAYS	5318	CALC ALLOW CHRG LES TPL IS ZER	\$ 2,793.20	2
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 26,638.23	22
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 29,255.10	25
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 2,316.33	2
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 55,893.33	47
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 26,638.23	22
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 1,678.50	3
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 16,759.57	14
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 11,841.95	12
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 22,400.40	20
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 5,041.45	4
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 30,925.57	30
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 9,463.75	10
01 - 30 DAYS	0750	TPL-FOR BENFC-RESUB W/TPL EOB	\$ 1,834.00	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 116,785.82	107
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 1,750.00	1
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 1,998.25	2
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 76,634.99	64
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 227.25	3
01 - 30 DAYS	2200	WEB CLAIM WITH ATTACHMENT	\$ 1,680.00	2
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 2,384.41	2
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 23,180.84	23
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 1,805.13	2
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 22,959.00	18
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 19,654.89	16
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 10,282.08	10
31-90 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$ 1,500.00	1
31-90 DAYS	0112	DOS CANNOT SPAN MONTHS	\$ 1,500.00	1

31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 10,429.41	10
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 2,418.45	2
31-90 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 1,536.00	2
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 10,429.41	10
31-90 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 1,500.00	1
01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$ 1,500.00	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 29,059.04	32
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 24,425.96	20
01 - 30 DAYS	0112	DOS CANNOT SPAN MONTHS	\$ 1,500.00	1
01 - 30 DAYS	0118	MCARE ALLOWED AMT CNFL	\$ 3,710.00	4
01 - 30 DAYS	0127	LAST DOS AFTER RECEIPT DATE	\$ 1,500.00	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 30,383.19	29
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 3,675.88	4
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 27,241.61	26
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 2,623.00	2
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 49,843.52	51
01 - 30 DAYS	0596	DIAG RELATED CODE INVALID	\$ 1,828.75	2
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 21,999.00	27
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 301,410.94	324
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 1,563.00	2
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 7,494.25	6
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 102,917.75	90
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 6,936.01	38
01 - 30 DAYS	2200	WEB CLAIM WITH ATTACHMENT	\$ 3,067.50	3
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 63,040.41	60
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 98,674.64	105
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 20,983.80	18
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 9,640.07	8
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 10,464.70	9
01 - 30 DAYS	5318	CALC ALLOW CHRG LES TPL IS ZER	\$ 2,835.08	3
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 17,150.03	14
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 19,763.71	17
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 2,282.29	2
31-90 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 1,750.00	1
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 36,913.74	31
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 12,399.54	10
31-90 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 40.50	1
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 17,150.03	14
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 20,754.58	24
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 25,513.98	21
01 - 30 DAYS	0118	MCARE ALLOWED AMT CNFL	\$ 223.13	2
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 60,867.45	54
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 34,927.69	31
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 9,469.87	8

01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 88,507.64	96
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 10,253.10	8
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 13,195.75	16
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 422,105.52	499
01 - 30 DAYS	1211	XOVER DEDUCT EXCDS ALLOW MAX	\$ 3,731.00	4
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 1,802.50	2
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 2,248.25	2
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 152,281.77	127
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 13,962.59	111
01 - 30 DAYS	2200	WEB CLAIM WITH ATTACHMENT	\$ 1,612.50	2
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 11,494.90	12
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 81,238.26	87
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 106,211.93	114
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 32,644.80	27
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 61,269.71	52
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 33,349.37	32
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 6,760.29	6
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 12,365.74	10
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 2,623.00	2
31-90 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 1,500.00	1
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 19,126.03	16
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 1,855.00	2
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 4,137.29	4
01 - 30 DAYS	0032	CLAIM TYPE CANNOT BE ASSIGNED	\$ 2,657.04	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 23,910.67	69
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 83,218.65	81
01 - 30 DAYS	0118	MCARE ALLOWED AMT CNFL	\$ 3,665.38	3
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 66,929.40	90
01 - 30 DAYS	0144	EV AUTHORIZATION ON FILE	\$ 3,552.50	3
01 - 30 DAYS	0169	MEDCARE ALLOWED AMOUNT = ZERO	\$ 3,683.76	4
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 83,140.92	106
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 51,676.48	83
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 105,125.84	127
01 - 30 DAYS	0332	DIAG/RELATED DIAG CODE MISSING	\$ 1,500.00	1
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 6,387.63	6
01 - 30 DAYS	0750	TPL-FOR BENFC-RESUB W/TPL EOB	\$ 1,828.75	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 715,491.48	1,001
01 - 30 DAYS	1211	XOVER DEDUCT EXCDS ALLOW MAX	\$ 2,072.88	3
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 1,750.00	1
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 7,869.00	6
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 468,912.22	706
01 - 30 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 9,122.10	55
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 6,847.08	8
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 68,487.33	100

01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 82,941.66	117
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 238,971.76	421
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$ 3,552.50	3
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 106,638.87	92
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 43,952.21	46
01 - 30 DAYS	5318	CALC ALLOW CHRG LES TPL IS ZER	\$ 1,750.00	1
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 1,500.00	1
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 16,298.87	15
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 4,960.00	4
31-90 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 3,000.00	2
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 17,798.87	16
31-90 DAYS	2090	NO DED/COINS ON XOVER CLM LINE	\$ 52.50	1
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 1,500.00	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 2,926.02	5
01 - 30 DAYS	0102	SUSPECT DUPLICATE CLAIM	\$ 11,343.37	9
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 62,150.30	65
01 - 30 DAYS	0144	EV AUTHORIZATION ON FILE	\$ 1,933.75	2
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 14,948.46	14
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 15,714.89	16
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 25,402.76	27
01 - 30 DAYS	0610	WEB X-OVER MANUAL REVIEW	\$ 3,359.50	4
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 160,005.59	172
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 1,750.00	1
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 3,139.49	3
01 - 30 DAYS	1692	MULTIPLE REFERRING PIDS FOUND	\$ 108,222.03	118
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 28,627.38	40
01 - 30 DAYS	5228	SERVICE COVERED BY D-SNP	\$ 8,302.97	11
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 34,232.44	37
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$ 1,933.75	2
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 23,981.19	20
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 36,108.92	41
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 5,855.97	6
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 18,708.41	20
31-90 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 1,750.00	1
31-90 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$ 4,100.63	4
31-90 DAYS	0412	SERV PROV NOT ON FILE	\$ 1,750.00	1
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 1,750.00	1
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 26,314.38	27
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 1,907.50	2
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 5,855.97	6
31-90 DAYS	5671	INVALID REND/ATTEN NPI	\$ 1,750.00	1
				19,747
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 156.16	3
				3

01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	87.76	1
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	87.76	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	87.76	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	715.88	18
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	497.18	15
					36
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	43.88	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	43.88	1
					2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	3,035.77	16
01 - 30 DAYS	0135	CLAIM PRICED AT ZERO	\$	1,038.84	8
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	10,904.15	13
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	873.49	3
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$	39,589.90	15
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$	1,832.31	17
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$	3,629.48	6
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$	17,302.91	32
01 - 30 DAYS	0365	PROC/PLACE OF SVC CNFL	\$	2,072.22	12
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$	20,243.24	38
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	8,521.90	71
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$	17,302.91	32
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$	37,901.47	117
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$	19,879.91	35
01 - 30 DAYS	0432	PROC CODE REQUIRES REVIEW	\$	549.40	4
01 - 30 DAYS	0439	PROC NOT A BENEFIT FOR DOS	\$	489.44	4
01 - 30 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$	2,577.00	3
01 - 30 DAYS	1122	PROC CODE/MODIFIER MATCH	\$	940.85	5
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$	19,474.50	36
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$	216.11	1
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$	26,600.98	48
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$	8,521.90	71
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	3,230.16	11
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	4,590.50	50
01 - 30 DAYS	5229	INVALID TAXONOMY	\$	9,875.20	64
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$	11,606.17	11
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	5,951.42	12
01 - 30 DAYS	5302	INELIGIBLE PROVIDER COS	\$	251.38	1
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$	17,302.91	32
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$	11,437.16	9
01 - 30 DAYS	5673	NO MATCHING REND/ATTND PID	\$	4,066.33	16
01 - 30 DAYS	6786	S9485 CONTRA	\$	17,345.22	31
01 - 30 DAYS	6941	S9485 LIMIT	\$	1,162.81	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	39,589.90	15
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	23.88	1

31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 15,119.18	17
31-90 DAYS	0221	BENFC NAME MISMATCH	\$ 1,080.55	5
31-90 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 6,786.84	2
31-90 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 216.11	1
31-90 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 1,512.77	7
31-90 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 106,484.09	374
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 106,448.60	385
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 108,850.69	398
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 108,850.69	398
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 1,080.55	5
31-90 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 1,975.77	3
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 108,850.69	398
31-90 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 97,754.80	357
31-90 DAYS	5218	SERVICE COVERED BY MCO.	\$ 134.17	1
31-90 DAYS	5229	INVALID TAXONOMY	\$ 104,758.56	380
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 23.88	1
31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 6,786.84	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 81,646.44	431
01 - 30 DAYS	0127	LAST DOS AFTER RECEIPT DATE	\$ 1,162.81	1
01 - 30 DAYS	0135	CLAIM PRICED AT ZERO	\$ 2,596.06	19
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 12,645.91	29
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 2,812.71	19
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 290,702.98	110
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 15,825.62	47
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 9,062.90	25
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 40,658.63	80
01 - 30 DAYS	0365	PROC/PLACE OF SVC CNFL	\$ 4,174.44	25
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 60,531.69	73
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 7,813.50	58
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 40,658.63	80
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 221,402.79	241
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 72,304.66	113
01 - 30 DAYS	0432	PROC CODE REQUIRES REVIEW	\$ 1,250.10	7
01 - 30 DAYS	0439	PROC NOT A BENEFIT FOR DOS	\$ 1,345.96	12
01 - 30 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 44,555.08	22
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 3,602.23	16
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 453.44	5
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 75,582.88	79
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 75,004.88	121
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 16,696.74	105
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 1,595.03	3
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 11,903.15	94
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 59,859.62	115
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 1,082.40	6

01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 20,904.56	39
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 10,131.00	25
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 40,658.63	80
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 21,491.80	17
01 - 30 DAYS	5673	NO MATCHING REND/ATTND PID	\$ 5,931.80	17
01 - 30 DAYS	6312	MHRS COMMUNITY SUPPORT LIMIT	\$ 51.54	1
01 - 30 DAYS	6786	S9485 CONTRA	\$ 25,389.38	50
01 - 30 DAYS	6941	S9485 LIMIT	\$ 9,144.13	5
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 290,702.98	110
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 7,371.86	13
31-90 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 10,180.26	4
31-90 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 216.11	1
31-90 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 7,545.61	14
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 7,078.12	12
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 7,812.69	16
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 7,812.69	16
31-90 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 164.00	1
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 7,812.69	16
31-90 DAYS	5229	INVALID TAXONOMY	\$ 7,398.76	14
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 204.28	2
31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 10,180.26	4
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 268.34	2
01 - 30 DAYS	0135	CLAIM PRICED AT ZERO	\$ 750.78	2
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 1,424.56	9
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 1,429.66	10
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 37,327.62	13
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 574.74	6
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 3,858.87	10
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 31,433.62	28
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 30,289.52	23
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 1,375.49	10
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 31,433.62	28
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 1,552.25	10
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 31,433.62	28
01 - 30 DAYS	0432	PROC CODE REQUIRES REVIEW	\$ 750.78	2
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 164.00	1
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 204.28	2
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 11,282.22	22
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 216.11	1
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 31,433.62	28
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 2,615.53	17
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 5,311.40	50
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 5,295.77	17
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 946.11	5

01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 2,658.79	3
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 957.14	6
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 31,433.62	28
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 28,404.26	14
01 - 30 DAYS	6312	MHRS COMMUNITY SUPPORT LIMIT	\$ 25.77	1
01 - 30 DAYS	6358	MHRS COMMUNITY SUPPORT CONTRA	\$ 77.31	2
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 37,327.62	13
31-90 DAYS	0135	CLAIM PRICED AT ZERO	\$ 9,286.46	68
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 718.87	2
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 27,677.29	50
31-90 DAYS	0221	BENFC NAME MISMATCH	\$ 586.84	3
31-90 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 96,178.57	40
31-90 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 3,473.59	24
31-90 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 432.22	2
31-90 DAYS	0365	PROC/PLACE OF SVC CNFL	\$ 1,051.12	8
31-90 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 396,636.46	1,167
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 415,522.05	1,328
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 419,375.74	1,350
31-90 DAYS	0432	PROC CODE REQUIRES REVIEW	\$ 7,878.93	65
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 251.38	1
31-90 DAYS	0439	PROC NOT A BENEFIT FOR DOS	\$ 244.72	2
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 419,375.74	1,350
31-90 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 467.49	2
31-90 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 12,188.48	19
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 419,375.74	1,350
31-90 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 14,757.04	60
31-90 DAYS	5218	SERVICE COVERED BY MCO.	\$ 1,202.73	8
31-90 DAYS	5229	INVALID TAXONOMY	\$ 373,844.35	1,274
31-90 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 1,759.66	3
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 718.87	2
31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 95,015.76	39
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 5,618.79	10
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 4,524.56	2
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 5,618.79	10
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 4,524.56	2
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 9,011.71	19
31-90 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 4,524.56	2
31-90 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 467.49	2
31-90 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 7,268.22	26
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 6,959.68	27
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 7,608.01	30
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 7,608.01	30
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 7,608.01	30
31-90 DAYS	5229	INVALID TAXONOMY	\$ 2,322.05	11

31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 4,524.56	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 61,214.46	203
01 - 30 DAYS	0135	CLAIM PRICED AT ZERO	\$ 375.62	3
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 3,533.97	8
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 925.07	5
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 45,245.60	16
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 2,755.54	31
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 8,854.47	31
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 30,745.59	42
01 - 30 DAYS	0365	PROC/PLACE OF SVC CNFL	\$ 164.80	1
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 26,644.74	15
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 5,348.61	49
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 30,745.59	42
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 9,682.09	101
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 36,594.63	76
01 - 30 DAYS	0432	PROC CODE REQUIRES REVIEW	\$ 253.26	2
01 - 30 DAYS	0439	PROC NOT A BENEFIT FOR DOS	\$ 122.36	1
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 664.53	8
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 19,569.23	9
01 - 30 DAYS	3822	SERVICE COVERED BY PACE	\$ 934.98	4
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 30,745.59	42
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 8,464.67	67
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 87.52	1
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 13,598.65	136
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 8,920.62	52
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 2,037.76	11
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 4,768.52	14
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 757.76	5
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 30,745.59	42
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 26,644.74	15
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 45,245.60	16
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 1,162.81	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 702.50	4
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 384.68	3
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 21,491.66	8
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 1,394.55	14
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 216.11	1
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 9,705.97	15
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 8,793.23	6
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 2,975.00	26
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 9,705.97	15
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 2,666.84	25
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 13,499.74	36
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 72.66	2

01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 11,547.02	9
01 - 30 DAYS	3245	INVLD DIAG FOR PSY & OLP PROVS	\$ 77.31	1
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 9,705.97	15
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 3,424.02	28
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 7,737.52	75
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 1,432.66	12
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 360.80	2
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 6,677.81	8
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 216.11	1
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 9,705.97	15
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 8,672.12	5
01 - 30 DAYS	6358	MHRS COMMUNITY SUPPORT CONTRA	\$ 51.54	1
01 - 30 DAYS	6941	S9485 LIMIT	\$ 2,325.62	2
01 - 30 DAYS	6969	COMM SUPPORT AUDIO-ONLY LIMIT	\$ 51.54	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 21,491.66	8
31-90 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 216.11	1
31-90 DAYS	0365	PROC/PLACE OF SVC CNFL	\$ 329.60	2
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 329.60	2
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 329.60	2
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 257.71	2
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 329.60	2
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 329.60	2
31-90 DAYS	5218	SERVICE COVERED BY MCO.	\$ 329.60	2
31-90 DAYS	5229	INVALID TAXONOMY	\$ 329.60	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 3,825.64	3
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 6,733.26	9
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 42,983.32	15
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 4,222.15	5
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 4,509.24	6
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 29,926.54	22
01 - 30 DAYS	0365	PROC/PLACE OF SVC CNFL	\$ 164.80	1
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 28,781.26	12
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 689.62	6
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 29,926.54	22
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 31,369.74	30
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 318.88	2
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 4,013.87	9
01 - 30 DAYS	3245	INVLD DIAG FOR PSY & OLP PROVS	\$ 73.86	1
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 29,926.54	22
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 689.62	6
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 1,903.02	20
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 2,478.39	2
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 5,408.73	13
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 6,154.98	5

01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 29,926.54	22
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 28,781.26	12
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 42,983.32	15
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 251.38	1
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 38,082.14	48
31-90 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 28,278.50	10
31-90 DAYS	0365	PROC/PLACE OF SVC CNFL	\$ 164.80	1
31-90 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 1,162.81	1
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 1,750.43	5
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 587.62	4
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 2,091.01	13
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 1,750.43	5
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 1,750.43	5
31-90 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 87.52	1
31-90 DAYS	5218	SERVICE COVERED BY MCO.	\$ 224.51	1
31-90 DAYS	5229	INVALID TAXONOMY	\$ 500.10	3
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 251.38	1
31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 28,278.50	10
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 10,810.00	12
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 3,609.53	2
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 50,901.30	17
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 756.88	7
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 5,706.00	12
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 30,326.58	46
01 - 30 DAYS	0365	PROC/PLACE OF SVC CNFL	\$ 164.80	1
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 27,766.72	15
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 41,379.64	219
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 30,231.06	42
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 980.57	14
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 33,009.68	57
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$ 72.66	2
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 8,710.55	9
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 30,326.58	46
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 42,122.45	219
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 1,162.81	1
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 7,783.08	75
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 5,971.40	22
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 428.79	3
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 4,582.88	8
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 7,218.62	4
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 30,231.06	42
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 27,524.50	13
01 - 30 DAYS	6941	S9485 LIMIT	\$ 1,162.81	1
01 - 30 DAYS	6969	COMM SUPPORT AUDIO-ONLY LIMIT	\$ 206.16	2

01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 50,901.30	17
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 970.25	3
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 360.80	2
31-90 DAYS	5229	INVALID TAXONOMY	\$ 251.38	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 3,425.09	2
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 3,849.08	4
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 30,540.78	11
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 431.78	2
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 2,107.85	18
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 14,050.45	62
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 7,918.12	9
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 566.73	19
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 13,668.37	46
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 382.08	16
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 16,086.19	59
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 23,152.32	12
01 - 30 DAYS	3245	INVLD DIAG FOR PSY & OLP PROVS	\$ 73.86	1
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 14,050.45	62
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 975.21	7
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 1,162.81	1
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 4,905.68	41
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 382.08	16
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 2,985.97	22
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 565.08	4
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 13,668.37	46
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 7,918.12	9
01 - 30 DAYS	6941	S9485 LIMIT	\$ 2,325.62	2
01 - 30 DAYS	6970	COMM SUPPORT LIMIT	\$ 51.54	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 30,540.78	11
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 4,795.45	6
31-90 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 3,393.42	1
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 243.46	7
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 243.46	7
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 1,384.91	8
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 243.46	7
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 243.46	7
31-90 DAYS	5218	SERVICE COVERED BY MCO.	\$ 95.52	4
31-90 DAYS	5229	INVALID TAXONOMY	\$ 746.22	8
31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 3,393.42	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 34,884.30	30
01 - 30 DAYS	0127	LAST DOS AFTER RECEIPT DATE	\$ 1,162.81	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 21,304.68	13
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 431.78	2
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 36,196.48	13

01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 3,393.42	1
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 10,391.60	20
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 2,289.65	28
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 638.44	15
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 1,979.21	15
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 310.44	13
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 3,779.25	24
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 17,188.79	10
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 14,402.45	65
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 1,567.58	8
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 2,325.62	2
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 5,563.16	46
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 310.44	13
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 1,884.40	15
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 408.56	4
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 14,514.81	21
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 1,979.21	15
01 - 30 DAYS	6358	MHRS COMMUNITY SUPPORT CONTRA	\$ 25.77	1
01 - 30 DAYS	6941	S9485 LIMIT	\$ 5,814.05	5
01 - 30 DAYS	6970	COMM SUPPORT LIMIT	\$ 51.54	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 36,196.48	13
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 23.88	1
31-90 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 47.76	2
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 167.16	7
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 167.16	7
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 1,427.60	8
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 167.16	7
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 167.16	7
31-90 DAYS	5218	SERVICE COVERED BY MCO.	\$ 47.76	2
31-90 DAYS	5229	INVALID TAXONOMY	\$ 167.16	7
31-90 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 23.88	1
01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$ 3,488.43	3
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 20,980.23	20
01 - 30 DAYS	0112	DOS CANNOT SPAN MONTHS	\$ 1,162.81	1
01 - 30 DAYS	0127	LAST DOS AFTER RECEIPT DATE	\$ 1,162.81	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 15,147.28	14
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 26,016.22	10
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 4,978.27	7
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 22,350.53	38
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 21,806.38	10
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 850.79	16
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 21,758.25	25
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 2,917.90	15
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 11,792.19	28

01 - 30 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 2,325.62	2
01 - 30 DAYS	1253	CLAIM DOS/BENFC DOD CONFLICT	\$ 1,162.81	1
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$ 1,162.81	1
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 8,264.37	6
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 24,676.15	40
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 1,674.83	10
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 2,520.44	22
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 592.28	13
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 711.71	6
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 1,162.81	1
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 5,593.42	5
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 21,758.25	25
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 19,480.76	8
01 - 30 DAYS	6787	S9484 CONTRA	\$ 1,162.81	1
01 - 30 DAYS	6941	S9485 LIMIT	\$ 10,465.29	9
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 26,016.22	10
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 180.40	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 2,537.54	3
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 30,540.78	11
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$ 3,393.42	1
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 4,724.66	12
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 5,880.12	29
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 3,393.42	1
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 325.71	11
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$ 5,665.20	20
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 13,160.22	15
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 6,338.73	23
01 - 30 DAYS	1711	PRIN DIAG INVALID	\$ 15,432.09	9
01 - 30 DAYS	1719	1ST DIAGNOSIS INVALID	\$ 15,432.09	9
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 5,679.58	3
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 5,880.12	29
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 559.81	4
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 1,680.24	17
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 2,477.20	10
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 1,511.64	12
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 4,524.56	2
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 4,775.94	3
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 5,665.20	20
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$ 3,393.42	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 30,540.78	11
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 251.38	1
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 721.60	4
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 251.38	1
01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$ 45,497.12	18

01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	216.11	1
01 - 30 DAYS	0112	DOS CANNOT SPAN MONTHS	\$	5,655.70	2
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	6,996.75	14
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	2,431.49	7
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$	13,573.68	4
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$	1,793.18	3
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$	9,734.03	27
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$	4,692.23	25
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$	1,402.47	4
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	56,346.04	160
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$	4,501.19	17
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$	191.04	8
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$	6,030.22	26
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$	124.06	1
01 - 30 DAYS	1711	PRIN DIAG INVALID	\$	22,450.76	51
01 - 30 DAYS	1719	1ST DIAGNOSIS INVALID	\$	22,450.76	51
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$	4,660.07	6
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$	4,692.23	25
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$	56,379.51	153
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	2,708.72	27
01 - 30 DAYS	5229	INVALID TAXONOMY	\$	7,976.88	14
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$	658.49	5
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$	3,615.59	10
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	2,840.21	9
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$	4,501.19	17
01 - 30 DAYS	5672	MULTIPLE REND/ATTEND PIDS FND	\$	754.14	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	13,573.68	4
31-90 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	251.38	1
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	2,262.28	1
31-90 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$	2,262.28	1
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$	360.80	2
31-90 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	251.38	1
31-90 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	2,262.28	1
01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$	169,796.76	62
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	92,905.25	317
01 - 30 DAYS	0112	DOS CANNOT SPAN MONTHS	\$	2,262.28	1
01 - 30 DAYS	0135	CLAIM PRICED AT ZERO	\$	213.48	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	10,229.73	20
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	6,068.21	10
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$	63,343.84	21
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$	1,828.89	3
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$	19,218.54	37
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$	4,748.18	34
01 - 30 DAYS	0332	DIAG/RELATED DIAG CODE MISSING	\$	1,162.81	1

01 - 30 DAYS	0365	PROC/PLACE OF SVC CNFL	\$	328.00	2
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$	648.33	3
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	75,614.86	245
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$	4,437.74	21
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$	19,421.41	32
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$	5,533.05	27
01 - 30 DAYS	0432	PROC CODE REQUIRES REVIEW	\$	213.48	1
01 - 30 DAYS	0436	AUTH REQ- PA IS MISS/INV	\$	15,867.63	6
01 - 30 DAYS	0596	DIAG RELATED CODE INVALID	\$	1,162.81	1
01 - 30 DAYS	1122	PROC CODE/MODIFIER MATCH	\$	159.44	1
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$	193.32	2
01 - 30 DAYS	1711	PRIN DIAG INVALID	\$	71,792.59	106
01 - 30 DAYS	1719	1ST DIAGNOSIS INVALID	\$	71,792.59	106
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$	12,035.08	16
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$	12,767.72	91
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$	76,723.90	243
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	13,273.73	111
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	5,953.41	47
01 - 30 DAYS	5229	INVALID TAXONOMY	\$	17,589.15	43
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$	950.71	8
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$	13,838.58	17
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	5,206.28	14
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$	4,437.74	21
01 - 30 DAYS	6941	S9485 LIMIT	\$	17,442.15	15
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	63,343.84	21
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	23.88	1
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$	180.40	1
01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$	159,019.79	60
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	39,535.54	34
01 - 30 DAYS	0112	DOS CANNOT SPAN MONTHS	\$	7,949.65	3
01 - 30 DAYS	0127	LAST DOS AFTER RECEIPT DATE	\$	3,488.43	3
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	12,420.86	20
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	180.40	1
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$	73,524.10	22
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$	360.80	2
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$	16,159.75	15
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$	2,287.00	27
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$	216.11	1
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	26,936.95	80
01 - 30 DAYS	0412	SERV PROV NOT ON FILE	\$	1,811.76	13
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$	11,284.02	21
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$	4,454.09	27
01 - 30 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$	224.51	1
01 - 30 DAYS	1255	BENEFICIARY OVER 65 BILL MCARE	\$	2,262.28	1

01 - 30 DAYS	1711	PRIN DIAG INVALID	\$ 29,347.22	27
01 - 30 DAYS	1719	1ST DIAGNOSIS INVALID	\$ 29,347.22	27
01 - 30 DAYS	2333	1ST DIAG NOT ICD 10	\$ 1,162.11	1
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 18,797.08	17
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 2,287.00	27
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$ 27,641.58	72
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 22,664.43	22
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 3,322.79	30
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 17,860.39	29
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$ 1,770.59	14
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$ 3,770.18	9
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$ 17,514.28	14
01 - 30 DAYS	5410	TREATING PROVIDER MISSING	\$ 1,811.76	13
01 - 30 DAYS	6787	S9484 CONTRA	\$ 1,182.81	1
01 - 30 DAYS	6941	S9485 LIMIT	\$ 16,299.34	14
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$ 73,524.10	22
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$ 3,049.42	15
31-90 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$ 216.11	1
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 952.81	7
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 952.81	7
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$ 360.80	2
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$ 952.81	7
31-90 DAYS	1711	PRIN DIAG INVALID	\$ 224.51	1
31-90 DAYS	1719	1ST DIAGNOSIS INVALID	\$ 224.51	1
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 952.81	7
31-90 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$ 952.81	7
31-90 DAYS	5229	INVALID TAXONOMY	\$ 952.81	7
01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$ 40,092.66	15
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$ 1,162.81	1
01 - 30 DAYS	0112	DOS CANNOT SPAN MONTHS	\$ 2,262.28	1
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$ 2,513.66	2
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$ 2,262.28	1
01 - 30 DAYS	0238	SUB UNITS EXCEED MAX ALLOWED	\$ 13,573.68	4
01 - 30 DAYS	0266	QMB BENFC/ BILL XOVER ONLY	\$ 6,786.84	2
01 - 30 DAYS	0313	CAT OF SERV CANNOT BE DTRMND	\$ 95.52	4
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$ 95.52	4
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$ 6,002.60	7
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$ 180.40	1
01 - 30 DAYS	1711	PRIN DIAG INVALID	\$ 5,655.70	2
01 - 30 DAYS	1719	1ST DIAGNOSIS INVALID	\$ 5,655.70	2
01 - 30 DAYS	2718	BH CLAIM MUST HAVE BH DX CODE	\$ 5,655.70	2
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$ 95.52	4
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$ 275.92	5
01 - 30 DAYS	5229	INVALID TAXONOMY	\$ 6,002.60	7

01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	251.38	1
01 - 30 DAYS	6941	S9485 LIMIT	\$	1,162.81	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	13,573.68	4
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	1,162.81	1
31-90 DAYS	0433	PROVIDER LICENSE EXPIRED >30D	\$	180.40	1
					22,269
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	211.69	5
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	124.21	4
					9
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	65.61	1
01 - 30 DAYS	2296	SBHS REQ REFER PROV NPI - SUSP	\$	65.61	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	65.61	1
					3
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	24.94	1
31-90 DAYS	1694	REFERRING NPI NOT ON FILE	\$	24.94	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	266.00	6
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	153.58	3
					11
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	131.17	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	43.88	1
					4
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	201.44	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	1,611.52	4
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	2,417.28	6
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	1,812.96	5
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	1,007.20	3
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	1,007.20	3
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	2,014.40	5
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	201.44	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	1,611.52	5
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	402.88	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	201.44	1
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	402.88	1
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	1,208.64	4
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	3,021.60	10
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	402.88	1
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	11,079.20	31
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$	402.88	1
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	402.88	1
01 - 30 DAYS	2296	SBHS REQ REFER PROV NPI - SUSP	\$	402.88	1
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	1,611.52	5
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	51,971.52	150
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	1,611.52	4
01 - 30 DAYS	2296	SBHS REQ REFER PROV NPI - SUSP	\$	1,611.52	4

01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	21,554.08	67
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	1,208.64	6
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	3,827.36	10
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	1,410.08	5
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	1,812.96	5
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	2,417.28	9
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	805.76	3
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	19,094.64	59
					412
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	102.20	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	102.20	3
					6
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	58.36	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	58.36	3
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	43.86	3
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	43.86	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	43.86	3
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	204.22	8
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	109.59	8
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	109.59	8
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	306.52	15
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	131.22	5
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	145.80	5
01 - 30 DAYS	0325	TRAUMA/ACCIDENT CLAIM	\$	29.16	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	1,596.51	35
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	29.16	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	626.94	23
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	24.94	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	773.01	25
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	197.19	12
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	222.13	13
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	825.55	33
					208
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	175.34	9
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	175.34	9
					18
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	218.00	1
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$	176.68	2
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	649.82	10
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	109.18	2
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	478.50	4
01 - 30 DAYS	6505	UR-NEW PATIENT EDITS/LIMITS	\$	436.00	1
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	477.06	9
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	1,362.00	6

01 - 30 DAYS	0077	SERV DATE SPAN MORE ONE DOS	\$	219.10	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	109.55	1
01 - 30 DAYS	0112	DOS CANNOT SPAN MONTHS	\$	219.10	2
01 - 30 DAYS	0126	FIRST DOS AFTER LAST DOS	\$	219.10	2
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	219.10	2
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	454.93	8
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	437.10	3
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	438.20	4
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	934.00	7
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	979.40	9
01 - 30 DAYS	0142	BENFC NOT ELIG - RECYCLE	\$	103.00	1
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	103.00	1
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$	219.80	2
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$	22.31	1
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	823.11	12
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	800.65	6
01 - 30 DAYS	8500	NCCI P2P DENIAL	\$	605.20	3
01 - 30 DAYS	8504	NCCI HIST CLM FOUND-ADJUST	\$	219.80	2
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	436.00	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	3,484.17	36
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	962.12	16
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	103.00	1
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	438.20	4
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	1,417.41	21
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	436.80	6
01 - 30 DAYS	0776	TPL-PAY & CHASE (EPSDT)	\$	436.00	1
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	438.20	4
01 - 30 DAYS	8500	NCCI P2P DENIAL	\$	1,308.00	3
01 - 30 DAYS	0135	CLAIM PRICED AT ZERO	\$	10.00	1
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	218.00	1
01 - 30 DAYS	0439	PROC NOT A BENEFIT FOR DOS	\$	10.00	1
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	109.55	1
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	218.36	4
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	218.36	4
01 - 30 DAYS	8500	NCCI P2P DENIAL	\$	1,362.59	4
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	436.00	2
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	901.50	4
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	436.72	8
01 - 30 DAYS	8500	NCCI P2P DENIAL	\$	872.00	2
01 - 30 DAYS	8500	NCCI P2P DENIAL	\$	1,308.00	3
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	1,018.00	8
01 - 30 DAYS	0150	MISSING/INVAL PLACE OF SERV.	\$	109.55	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	145.60	2
01 - 30 DAYS	6505	UR-NEW PATIENT EDITS/LIMITS	\$	436.00	1

					244
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	102.06	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	58.32	2
					5
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	158.54	6
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	158.54	6
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	116.96	4
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	14.58	1
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	14.58	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	14.58	1
					19
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	1,300.00	17
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	60.00	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	87.48	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	2,058.26	55
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	3,453.94	68
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	87.48	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	3,986.84	90
01 - 30 DAYS	8504	NCCI HIST CLM FOUND-ADJUST	\$	168.15	8
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	131.22	3
01 - 30 DAYS	2297	SBHS REQ REFER PROV NPI - DENY	\$	489.48	18
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	43.88	1
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	43.74	1
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	336.32	13
					280
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	320.76	7
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	58.32	3
					10
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	351.04	8
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	351.04	8
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	351.04	8
					24
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	24.94	1
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	24.94	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	29.24	2
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	29.24	2
					6
31-90 DAYS	0143	BENFC NOT ELIGIBLE/NOT FOUND	\$	149.64	4
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	87.48	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	87.48	3
					10
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	423.34	11
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	204.64	6
					17

01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	141.34	6
					6
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	2,519.01	73
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	1,578.98	56
					129
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	1,044.28	41
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	58.32	2
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	905.75	37
					80
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	102.38	3
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	102.38	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	102.38	3
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	87.62	2
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	87.62	2
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	43.88	1
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	467.08	15
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	204.64	12
					41
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	707.79	21
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	263.08	10
					31
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	1,030.00	9
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	1,080.00	8
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	900.00	6
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	450.00	3
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	1,300.00	9
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	1,300.00	9
					44
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	116.64	8
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	116.64	8
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	116.64	8
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	160.82	8
01 - 30 DAYS	1694	REFERRING NPI NOT ON FILE	\$	116.96	4
01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	73.06	4
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	73.06	4
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	233.88	12
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	1,373.51	50
01 - 30 DAYS	8501	NCCI P2P EDIT BYPASSED	\$	124.28	3
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	752.18	33
01 - 30 DAYS	8504	NCCI HIST CLM FOUND-ADJUST	\$	29.24	2
					144
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	1,182.38	32
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	818.96	16
01 - 30 DAYS	5145	DC PUBLIC PROV. PAST TIMELY LT	\$	117.00	4

01 - 30 DAYS	5275	SVC NOT COVERED FOR BENEFICIARY	\$	58.48	4
01 - 30 DAYS	5284	INELIGIBLE PROGRAM CODE	\$	58.48	4
01 - 30 DAYS	8503	NCCI MUE EDIT BYPASSED	\$	175.48	8
					68
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	224.51	1
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	402.36	6
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$	121.11	1
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	901.53	10
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$	180.40	1
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$	132.26	2
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$	769.27	8
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$	132.26	2
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	619.33	6
31-90 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$	118.34	2
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$	118.34	2
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$	118.34	2
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$	118.34	2
31-90 DAYS	5229	INVALID TAXONOMY	\$	118.34	2
01 - 30 DAYS	0101	EXACT DUPLICATE CLAIM	\$	1,162.72	16
01 - 30 DAYS	0221	BENFC NAME MISMATCH	\$	1,749.01	8
01 - 30 DAYS	0253	DIAG NOT VALID FOR DOS	\$	460.23	5
01 - 30 DAYS	0366	PROC/PROV/SPEC MISMATCH	\$	363.33	3
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	2,018.61	23
01 - 30 DAYS	0423	SERV PROV NOT IN BILLING GROUP	\$	2,433.02	12
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$	66.13	1
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$	661.30	10
01 - 30 DAYS	3905	BH - INVALID SERV PROV TYPE	\$	1,621.83	17
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$	462.91	7
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	173.15	1
01 - 30 DAYS	5229	INVALID TAXONOMY	\$	239.28	2
01 - 30 DAYS	5237	MEDICARE ELIG/NOT XOVER	\$	173.15	1
31-90 DAYS	0429	PROVIDER LICENSE EXPIRED	\$	268.34	2
31-90 DAYS	0721	SERVICING PROVIDER NOT ENROLL	\$	268.34	2
31-90 DAYS	3905	BH - INVALID SERV PROV TYPE	\$	268.34	2
01 - 30 DAYS	0365	PROC/PLACE OF SVC CNFL	\$	164.80	1
01 - 30 DAYS	0367	PROC/SERV PROV TYPE CNFL	\$	164.80	1
01 - 30 DAYS	1122	PROC CODE/MODIFER MATCH	\$	164.80	1
01 - 30 DAYS	3906	BH - INVALID SERVICE	\$	164.80	1
01 - 30 DAYS	5218	SERVICE COVERED BY MCO.	\$	164.80	1
01 - 30 DAYS	0429	PROVIDER LICENSE EXPIRED	\$	180.40	1
01 - 30 DAYS	5283	INELIGIBLE PROGRAM CODE	\$	180.40	1

49,175

EXCEPTION CODE	EXCEPTION DESCRIPTION	EXCEPTION REASONS (UNDUPLICATED COUNT ALL AGENCIES)	RANK
1122	PROC CODE/MODIFER MATCH	6,688	1
1692	MULTIPLE REFERRING PIDS FOUND	3,396	2
5284	INELIGIBLE PROGRAM CODE	2,822	3
8503	NCCI MUE EDIT BYPASSED	2,781	4
3905	BH - INVALID SERV PROV TYPE	2,516	5
423	SERV PROV NOT IN BILLING GROUP	2,440	
429	PROVIDER LICENSE EXPIRED	2,417	
5229	INVALID TAXONOMY	2,140	
5145	DC PUBLIC PROV. PAST TIMELY LT	1,972	
721	SERVICING PROVIDER NOT ENROLL	1,854	
366	PROC/PROV/SPEC MISMATCH	1,800	
5237	MEDICARE ELIG/NOT XOVER	1,748	
101	EXACT DUPLICATE CLAIM	1,711	
367	PROC/SERV PROV TYPE CNFL	1,084	
325	TRAUMA/ACCIDENT CLAIM	1,054	
3906	BH - INVALID SERVICE	1,020	
142	BENFC NOT ELIG - RECYCLE	989	
2297	SBHS REQ REFER PROV NPI - DENY	963	
5218	SERVICE COVERED BY MCO.	820	
221	BENFC NAME MISMATCH	814	
5283	INELIGIBLE PROGRAM CODE	802	
5228	SERVICE COVERED BY D-SNP	696	
143	BENFC NOT ELIGIBLE/NOT FOUND	684	
2090	NO DED/COINS ON XOVER CLM LINE	679	
266	QMB BENFC/ BILL XOVER ONLY	602	
102	SUSPECT DUPLICATE CLAIM	548	
313	CAT OF SERV CANNOT BE DTRMND	518	
412	SERV PROV NOT ON FILE	424	
5410	TREATING PROVIDER MISSING	418	
238	SUB UNITS EXCEED MAX ALLOWED	352	
2718	BH CLAIM MUST HAVE BH DX CODE	267	
1711	PRIN DIAG INVALID	196	
1719	1ST DIAGNOSIS INVALID	196	
253	DIAG NOT VALID FOR DOS	174	
77	SERV DATE SPAN MORE ONE DOS	164	
1255	BENEFICIARY OVER 65 BILL MCARE	124	
610	WEB X-OVER MANUAL REVIEW	117	
5672	MULTIPLE REND/ATTEND PIDS FND	104	
135	CLAIM PRICED AT ZERO	102	
432	PROC CODE REQUIRES REVIEW	81	

6786	S9485 CONTRA	81
1694	REFERRING NPI NOT ON FILE	73
169	MEDCARE ALLOWED AMOUNT = ZERO	70
5275	SVC NOT COVERED FOR BENEFICIARY	65
8501	NCCI P2P EDIT BYPASSED	56
6941	S9485 LIMIT	55
365	PROC/PLACE OF SVC CNFL	54
2296	SBHS REQ REFER PROV NPI - SUSP	54
433	PROVIDER LICENSE EXPIRED >30D	51
3822	SERVICE COVERED BY PACE	50
5673	NO MATCHING REND/ATTND PID	33
750	TPL-FOR BENFC-RESUB W/TPL EOB	22
2200	WEB CLAIM WITH ATTACHMENT	21
8504	NCCI HIST CLM FOUND-ADJUST	21
439	PROC NOT A BENEFIT FOR DOS	20
1253	CLAIM DOS/BENFC DOD CONFLICT	20
118	MCARE ALLOWED AMT CNFL	16
8500	NCCI P2P DENIAL	15
5318	CALC ALLOW CHRG LES TPL IS ZER	14
112	DOS CANNOT SPAN MONTHS	12
1211	XOVER DEDUCT EXCDS ALLOW MAX	12
127	LAST DOS AFTER RECEIPT DATE	7
117	INVALID 1ST PROC CODE MODIFIER	6
436	AUTH REQ- PA IS MISS/INV	6
5217	UNABLE TO PRICE MODIFIER	6
5671	INVALID REND/ATTEN NPI	6
116	ADD-ON PROC W/O PRIMARY PROC	5
144	EV AUTHORIZATION ON FILE	5
332	DIAG/RELATED DIAG CODE MISSING	4
6358	MHRS COMMUNITY SUPPORT CONTRA	4
596	DIAG RELATED CODE INVALID	3
3245	INVLD DIAG FOR PSY & OLP PROVS	3
5257	BENFC ON REVIEW NOT SUSP DUPE	3
6969	COMM SUPPORT AUDIO-ONLY LIMIT	3
32	CLAIM TYPE CANNOT BE ASSIGNED	2
103	POSSIBLE CONFLICT CLAIM	2
126	FIRST DOS AFTER LAST DOS	2
723	MCARE DED+COINS>ALWD AMT	2
757	TPL-IND ON CLM-NO RES ON FILE	2
6312	MHRS COMMUNITY SUPPORT LIMIT	2
6505	UR-NEW PATIENT EDITS/LIMITS	2
6787	S9484 CONTRA	2
6970	COMM SUPPORT LIMIT	2
150	MISSING/INVAL PLACE OF SERV.	1

776	TPL-PAY & CHASE (EPSDT)	1
2333	1ST DIAG NOT ICD 10	1
5302	INELIGIBLE PROVIDER COS	1

28. Identify each District of Columbia agency that submitted Medicaid claims, indicating if it was through an MCO, including HSCSN, or FFS, in FY 2025 and FY 2026, to date, and including the following information:

- a. **The number and total dollar amount of claims filed per agency each month;**

Response: See Attachment 1 for the total dollar amount of claims filed by 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 and the percentage and timetable of claims paid and denied within 30 and 90 days by month;

Response: Please see Attachment 1 to Q28 for the total dollar amount of claims denied per agency each month and the timetable of claims paid and denied within 30 and 90 days.

Based on FY 25 - 26 YTD denied claims history, the most common reasons for denials were:

- Procedure code/Modifier Match
- Multiple Referring Provider IDs Found
- Ineligible Program Code
- NCCI MUE Edit Bypassed
- Behavioral Health – Invalid service Provider Type

- c. Whether the agency uses a third-party billing agent;

Response: The third-party 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	MDONLINE
DC Behavioral Health (DBH) (formerly Dept of Mental Health)	Within agency
DC Fire Department & Ambulance Services (FEMS)	Office Ally

- 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:

DYRS will be integrated into the ASO in FY 2026 to comply with Section 5121 of the Consolidated Appropriations Act (CAA) of 2023, which requires State Medicaid Agencies to provide targeted case management (TCM) and screening and diagnostic services to eligible juveniles. Under this mandate, DYRS will begin seeking Medicaid reimbursement for certain state plan services delivered in the 30 days prior to a youth's release from a secure facility, as well as TCM services for at least 30 days post release. CMS clarified these requirements in State Health Official Letter #24004, issued in July 2024.

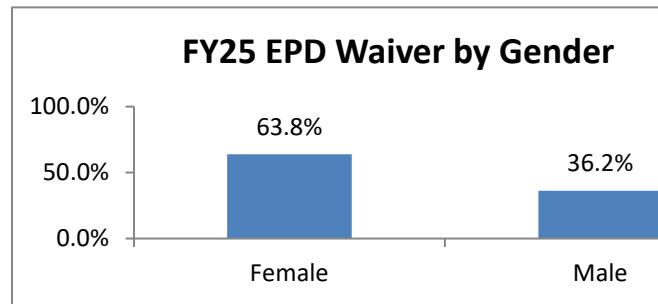
Although the statute sets an implementation date of January 1, 2025, CMS is allowing states to delay implementation until December 31, 2026, due to the operational and administrative complexity of establishing these new processes. The District's implementation timeline is no earlier than July 1, 2026, with HCRIA leading the effort. DYRS will manage Medicaid claiming for the covered services, supported by ASO's technical and operational expertise.

Currently, there are no additional opportunities to integrate other District agencies into the ASO. This is due to several factors, including agencies procuring their own billing vendors, discontinuing enrollment with DC Medicaid, or no longer providing Medicaid reimbursable services.

This report displays enrollment data for beneficiaries with spans from Oct 1, 2024 through Se
THE TABLES BELOW SHOW DISTRIBUTION BY GENDER FOR UNDL

Gender	EPD Waiver
Female	4,615
Male	2,624
TOTAL	7,239

Gender	EPD Waiver
Female	63.8%
Male	36.2%

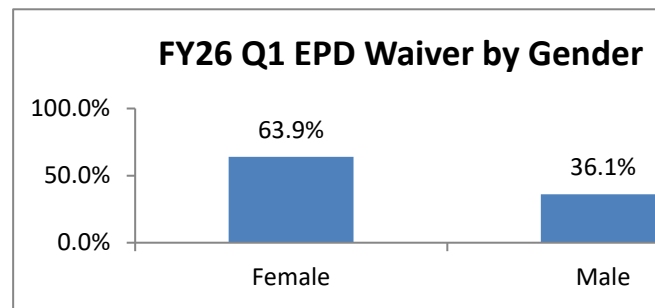


Source: DHCF Medicaid Management Information System (MMIS) data extracted December 31, 2025.

This report displays enrollment data for beneficiaries with spans from Oct 1, 2025 through De
THE TABLES BELOW SHOW DISTRIBUTION BY GENDER FOR UNDL

Gender	EPD Waiver
Female	4,326
Male	2,444
TOTAL	6,770

Gender	EPD Waiver
Female	63.9%
Male	36.1%



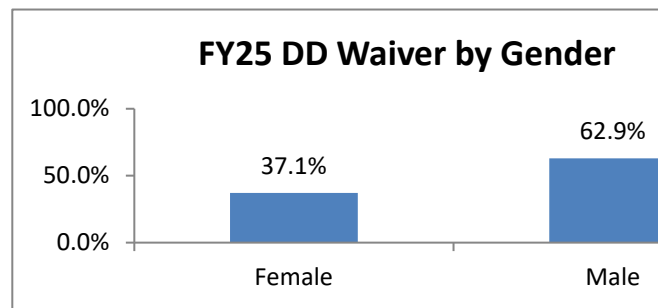
Source: DHCF Medicaid Management Information System (MMIS) data extracted December 31, 2025.



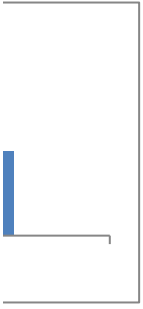
This report displays enrollment data for beneficiaries with spans from Oct 1, 2024 through Se
THE TABLES BELOW SHOW DISTRIBUTION BY GENDER FOR UNDU

Gender	DD Waiver
Female	741
Male	1,254
TOTAL	1,995

Gender	DD Waiver
Female	37.1%
Male	62.9%



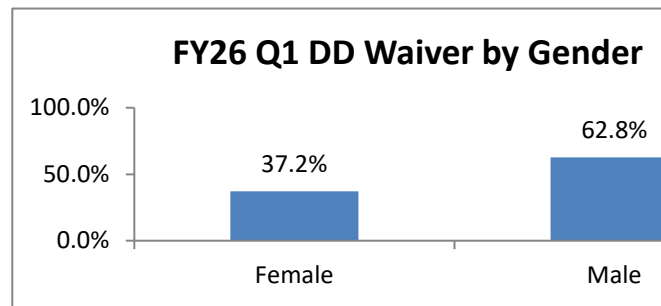
Source: DHCF Medicaid Management Information System (MMIS) data extracted December 31, 2025.



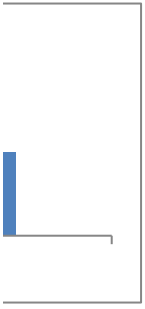
This report displays enrollment data for beneficiaries with spans from Oct 1, 2025 through De
THE TABLES BELOW SHOW DISTRIBUTION BY GENDER FOR UNDU

Gender	DD Waiver
Female	714
Male	1,203
TOTAL	1,917

Gender	DD Waiver
Female	37.2%
Male	62.8%



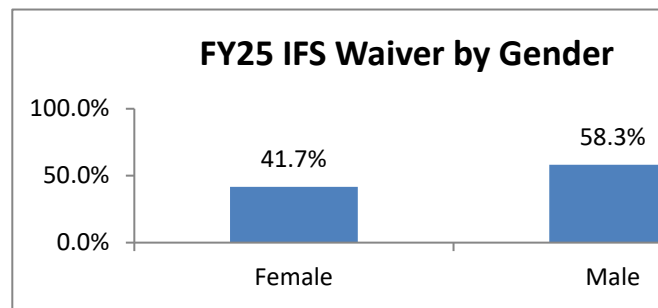
Source: DHCF Medicaid Management Information System (MMIS) data extracted December 31, 2025.



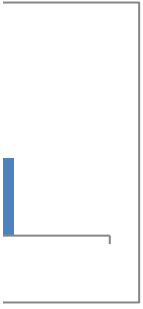
This report displays enrollment data for beneficiaries with spans from Oct 1, 2024 through Se
THE TABLES BELOW SHOW DISTRIBUTION BY GENDER FOR UNDU

Gender	IFS Waiver
Female	48
Male	67
TOTAL	115

Gender	IFS Waiver
Female	41.7%
Male	58.3%



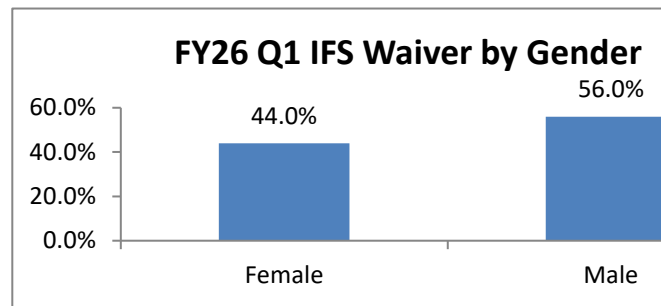
Source: DHCF Medicaid Management Information System (MMIS) data extracted December 31, 2025.



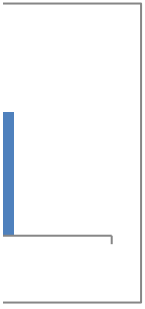
This report displays enrollment data for beneficiaries with spans from Oct 1, 2025 through De
THE TABLES BELOW SHOW DISTRIBUTION BY GENDER FOR UNDU

Gender	IFS Waiver
Female	44
Male	56
TOTAL	100

Gender	IFS Waiver
Female	44.0%
Male	56.0%



Source: DHCF Medicaid Management Information System (MMIS) data extracted December 31, 2025.



31. For each waiver program, please provide:

- a. **A description of and reason for any changes or planned changes in FY 2025 and FY 2026, to date:**
- b. **Enrollment, spending/costs, and utilization data by service provided, and cost per enrollee, both current and projected, including statistical information by gender, for FY 2025 and FY 2026, to date; and**
- c. **Enrollment cap, number of vacancies, or number of people on the waiting list, if applicable.**

Response:

- a. None
- b. See Attachment 1 to Q31 that includes all currently available enrollment and gender-based statistical data for each waiver program for FY 2025 and FY 2026 to date. Analysis of utilization by service type, spending, and cost-per-enrollee both current and projected are still being finalized. These components require additional validation to ensure accuracy. The Long-Term Care Program is working with the Office of Rates, Reimbursement and Financial Analysis to complete the remaining cost and utilization analyses. The full set of validated data will be provided once this review is complete to support program oversight and reporting.
- c. Currently, the 1915(c) Waiver programs do not have an enrollment cap or waitlist.

32. Please provide a list of all State Plan Amendments (SPAs) or demonstration projects submitted to CMS for approval in FY 2025 and FY 2026, to date, or planned for submission in the remainder of FY 2026. For each, please provide a narrative description, an update on its status, reason for the SPA, and details of any service changes that will occur because of the SPA.

Response:

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
Whole-Person Care Transformation (11-W-00331/3)	30 –day public comment period and ongoing stakeholder engagement series	Seeks authority to 1) fund BH, justice-involved reentry, and health-related social need (HRSN) services; 2) develop and maintain infrastructure to support the delivery of reentry and HRSN services	Effective: TBD Approved: Under Review Submitted: 6.6.24	Adds justice involved reentry and HRSN
DC-24-0013	None	CHIP From Conception to Birth Coverage - provides pregnancy-related care to targeted low-income children from conception to birth	Effective: 10.1.23 Approved: 1.17.25 Submitted: 5.17.24	Expands coverage of maternal health services for pregnant immigrants and their children
DC-24-0016	None	CHIP From Conception to Birth Coverage - provides pregnancy-related care to targeted low-income children from conception to birth	Effective: 10.1.23 Approved: 1.17.25 Submitted: 8.1.24	Expands coverage of maternal health services for pregnant immigrants and their children
DC-24-0017	None	Provides a supplemental payment in FY 25 to eligible an eligible group practice with at least five hundred (500) physicians that are members of the group	Effective: 10.1.24 Approved: 9.17.24 Submitted: 7.1.24	N/A

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC-24-0019	None	Renews the Districts Adult Day Health Program 1915(i) benefit.	Effective: 4.1.25 Approved: 3.10.25 Submitted: 9.30.24	N/A
DC-24-0020	None	Provides assurance for compliance with mandatory annual reporting for the My DC Health Homes core sets of quality measures.	Effective: 9.30.24 Approved: 10.9.24 Submitted: 4.19.24	N/A
DC-24-0021	None	Provides assurance for compliance with mandatory annual reporting for the My Health GPS Health Homes core sets of quality measures.	Effective: 9.30.24 Approved: 10.9.24 Submitted: 4.19.24	N/A
DC-24-0023	None	CHIP From Conception to Birth Coverage - provides pregnancy-related care to targeted low-income children from conception to birth	Effective: 10.1.23 Approved: 1.17.25 Submitted: 8.1.24	Expands coverage of maternal health services for pregnant immigrants and their children
DC-24-0025	None	Extended coverage of all FDA-approved over-the-counter COVID-19 test and test kits under purchased prior to September 30, 2025 (one year beyond the federally required time period of September 30, 2024).	Effective: 10.1.24 Approved: 8.28.25 Submitted: 12.20.24	Ends coverage of over-the-counter COVID-19 test effective 10.1.25.

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC-25-0001	None	Updates the fee schedule reimbursement rates for home health services.	Effective: 1.1.25 Approved: 4.10.25 Submitted: 2.4.25	N/A
DC-25-0002	None	Provides assurances in accordance with federally mandated quality reporting requirements for the Child Core Set and the behavioral health quality measures on the Adult Core Set outlined in 42 CFR 431.16 and 437.10 through 437.15.	Effective: 12.31.24 Approved: 3.14.25 Submitted: 2.25.25	N/A
DC-25-0003	None	Permits the District of Columbia Medicaid program to provide the Targeted Case Management and EPSDT benefits to justice-involved youth as described in section 5121 of the CAA, 2023. The effective date for this benefit is January 1, 2025.	Effective: 12.31.24 Approved: Under Review Submitted: 2.25.25	Provides access to Medicaid services for thirty (30) days prior to and thirty (30) days following release.
DC-25-0004	None	Provides an extension of the exception to the requirement of having a Recovery Audit Contractor (RAC) for an additional two (2) years, through May 31, 2027.	Effective: 6.1.25 Approved: 6.18.25 Submitted: 5.5.25	N/A
DC-25-0005	None	Permits the District of Columbia Medicaid Program to reimburse certain high-cost curative therapy drug products under fee-for-service (FFS).	Effective: 1.1.26 Approved: Under Review Submitted: 10.23.25	

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC-25-0006	None	Updates fee schedule rates for home health services.	Effective: 7.1.25 Approved: 10.2.25 Submitted: 7.14.25	N/A
DC-25-0007	None	Permits the District of Columbia Medicaid Program to exclude certain high-cost curative therapy drug products from the DRG reimbursement system and shall be reimbursed under fee-for-service (FFS).	Effective: 1.1.26 Approved: Under Review Submitted: 10.27.25	
DC-25-0008	None	Permits the District of Columbia Medicaid Program to exclude certain high-cost curative therapy drug products from the EAPG classification system.	Effective: 1.1.26 Approved: Under Review Submitted: 10.27.25	
DC-25-0009	None	Complies with actions implemented in Section 201 of the Consolidated Appropriations Act, 2024, which made the mandatory Medication-Assisted Treatment (MAT) for opioid use disorders (OUD) benefit permanent by amending Section 1905(a)(29) of the Social Security Act (the Act) to remove the end date of September 30, 2025.	Effective: 10.1.25 Approved: Under Review Submitted: 12.29.25	N/A
DC-25-0010	None	Updates rates for adult and pediatric dental services.	Effective: 10.1.25 Approved: Under Review Submitted: 12.16.25	N/A

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC-25-0012	None	Complies with the mandatory exception of the Medicaid clinic services benefit “four walls” requirement for Indian Health Services (IHS) and Tribal clinics and elects the optional exceptions for behavioral health clinics and clinics located in rural areas.	Effective: 6.1.25 Approved: 11.12.25 Submitted: 8.26.25	
DC-25-0013	None	Discontinues coverage of the optional eligibility group serving individuals with MAGI-based income above 133 percent of the federal poverty level (FPL); and reduce the income eligibility standard of its mandatory eligibility group serving parents and other caretaker relatives from 216 percent of the FPL to 133 percent of the FPL.	Effective: 1.1.26 Approved: 11.18.25 Submitted: 8.21.25	
DC-25-0014	None	For CHIP, demonstrates compliance with Section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT Act) and mental health parity requirements set forth at 42 CFR 457.496.	Effective: 10.1.24 Approved: Under Review Submitted: 9.30.25	None
DC-25-0015	None	Clarifies coverage requirements for Private Duty Nursing (PDN) ordered by and provided under the direction of a physician by registered nurses (RNs) and licensed practical nurses (LPNs), by removing the requirement that a beneficiary be “technology dependent” to receive PDN services.	Effective: 10.1.26 Approved: 11.18.25 Submitted: 8.21.25	
DC-25-0017	None	Removes individuals under age sixty-five (65) with income over one hundred thirty three percent (133%) of the federal poverty level (FPL) from the Section 1932(a) Managed Care SPA.	Effective: 1.1.26 Approved: 12.4.25 Submitted: 9.24.25	

Table 1: SPAs/Waivers Submitted to or Approved by CMS in FY25 and FY25, as of January 13, 2026

TN	Stakeholder Engagement	Description	Status	Service Change
DC Individual and Family Support (IFS) Waiver Renewal	Thirty (30) day public comment period and stakeholder meetings.	Renews the District's IFS waiver, expands remote support services, removes financial caps for certain services, updates reimbursement methodology for direct support workers and clarifies policies on training and certifications for providers.	Effective: 10.1.25 Approved: 9.30.25 Submitted: 7.18.25	See HCBS IFS Waiver 2025 Renewal dds.
DC People with Intellectual and Developmental Disabilities (IDD) Waiver Amendment	Two (2) thirty (30) day comment periods and stakeholder meetings.	Updates reimbursement methodology for direct support workers and clarifies service delivery policies to ensure quality of care and increase provider accountability and training.	Effective: TBD Approved: Under Review Submitted: 12.16.25	See HCBS IDD Waiver 2025 Amendment dds.

Table 2: FY25 and FY26 Anticipated SPA/Waiver Submissions

SPA/Waiver	Description
Adult Day Health Program	Changes the rate rebasing schedule for Adult Day Health Program services
Federally Qualified Health Centers	Changes the rate rebasing schedule for federally qualified health centers.

34. Please provide an update on how the DHCF is working with the District's managed care plans to ensure compliance with the Salazar Decree.

- a. **Please share any corrective action plans that were issued in FY 2025 and FY 2026 to date, how much in fines were issued by MCO, and whether the MCOs are meeting the standards of their CAPs.**

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 eligibility²; (4) adequate advance notice of termination from Medicaid benefits during annual renewal³; and (5) reimbursement of eligible out-of-pocket expenditures. The Parties had been engaged in settlement discussions to explore the District's exit strategy since 2022, and on October 31, 2025, the Parties reached a settlement agreement that was submitted to the Court and remains pending preliminary approval. The Settlement Agreement is not final until the judge holds a fairness hearing and approves. If it is approved, the consent decree will be vacated, and the Settlement Agreement will govern the District's obligations until the case is dismissed in October 2027.

In 2025, the District submitted all required reports to the Court under the consent decree and will continue to do so until the Settlement Agreement is final and the consent decree is vacated. Although 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.

Over 90% of the children insured by Medicaid are enrolled in Medicaid managed care plans (MCPs). MCPs 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. MCPs provide on-going outreach to the beneficiaries enrolled in the health plan, informing and encouraging them to seek needed and over-due services. In order to do this appropriately, regular reports are run by the MCPs to identify children who are due or overdue for particular preventive services or to identify beneficiaries who may need interventions based on multiple trips to the emergency room or some other unusual care pattern. As part of their contract with the District, MCPs are also responsible for various reporting requirements so that the District can monitor the outreach services being provided by the MCPs to the beneficiaries. This includes quarterly reports on utilization of, and notice and outreach for, EPSDT services.

Under the *Salazar* consent decree, the MCPs are expected to meet a certain threshold of well-child visit utilization, and if not met, corrective action plans and fines are imposed on the MCPs. In FY25, all four MCPs paid the fines imposed and were placed on corrective action plans, which are provided in the four corresponding attachments. (See Attachments 1 through 4 to Q34)

The fines imposed in FY25 were:

- AmeriHealth Caritas DC: \$360,045
- Health Services for Children with Special Needs: \$17,640
- MedStar Family Choice DC: \$246,780
- Wellpoint DC (formerly Amerigroup DC): \$227,655.

The MCPs are compliant with reporting deliverables and requirements to submit and implement their corrective action plans (CAPs) and payment of fines. DHCF's Division of Children's Health Services (DCHS) continues to work with the MCPs on outreach for preventive services in order to improve utilization of primary and dental care and ensure access to medical care for Medicaid-enrolled children.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance
MCO EPSDT Corrective Action Plan
October 1, 2024 to September 30, 2025

MCO: AmeriHealth Caritas District of Columbia (ACDC)

FY2024 Participant Ratio: 62% (Annual)

FY2025 Participation Ratio Goal: 80%

Quarterly Goal: Q1: 50%; Q2: 60%; Q3: 70% Q4: 80%

Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. 1 & 2	Qtr. 3	Qtr. 4
Total Eligible Receiving at least One Initial or Periodic Screen	Provider EPSDT Coding	Objective: To educate and support healthcare providers with documenting and coding EPSDT services in accordance with Medicaid guidelines. With the goal of improving service delivery, ensuring appropriate reimbursement, and increasing EPSDT compliance and participation rates among eligible children and adolescents. Description: Review and synthesize the existing materials, brochures, and similar resources available from DHCF and industry sources to develop a “job-aid” that will help educate and guide providers on how to properly code for EPSDT services. Target Population: Enrollees Age: 0 – 20 PLEASE NOTE: Completion and approval of the Job-Aid was finalized in June 2022. We look to initiate a pilot claims review in 2025 with select	○ For FY2025, we will be using the created materials for future provider group trainings and meetings.	○ We are continuing to use the created materials for during provider meetings where applicable.	○ We are continuing to use the created materials for during provider meetings where applicable.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance
MCO EPSDT Corrective Action Plan
October 1, 2024 to September 30, 2025

Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. 1 & 2	Qtr. 3	Qtr. 4
		providers to assess coding accuracy and identify opportunities to enhance compliance.			
		Objective: Provide training, resources, and job aid to providers to ensure proper coding on EPSDT claims. Description: Provide training, resources, and job aid to the providers to insure proper coding. Topics will include the proper codes to use with a special focus on coding for telemedicine and 2-part EPSDT well child visits. This action item includes: ○ Focus on individualized training sessions as appropriate for the top 10 provider practices (based upon EPSDT eligible enrollees on their panel) who are willing to participate. ○ The top 10 provider practices currently represent approximately 38K enrollees, which is approximately 90% of all enrollees. ○ For the remaining provider practices (representing 10% of our enrollee population), we provide access to training resources through our online provider portal: (Click Here) ○ These individualized training sessions may be included as part of the bi-monthly Outreach and Coordination meetings.	○ Discussions and planning of trainings are continuing to take place with multiple provider groups. Still waiting on opportunities to open to begin sessions. Staffing availability and changes at the provider locations have become a barrier.	○ Discussions and planning of trainings are continuing to take place with multiple provider groups. Still waiting on opportunities to begin sessions. Staffing availability and changes at the provider locations have become a barrier.	○ Discussions and planning of trainings are continuing to take place with multiple provider groups. As we assist with provider panel audits, we are searching for the best opportunity to begin training sessions.

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		Based upon provider interest and willingness to attend, offering, and executing zoom-based group trainings for all other providers around EPSDT services and proper EPSDT coding. Target Population: Enrollees Age: 0 – 20			
Total Eligible Receiving at least One Initial or Periodic Screen	Provider EPSDT CMS Participant Ratios	Objective: Have discussions with our top 5 providers around ways to Increase their EPSDT CMS 416 Participation Ratio Description: Meet bi-monthly with the top 5 provider practices (based upon EPSDT eligible enrollees on their panel) for Outreach and Coordination meetings. The top 5 practices currently represent approximately 33K enrollees, which is approximately 80% of all enrollees. We will expand this list as appropriate based upon any shifting enrollment patterns and our team’s capacity to hold additional meetings. PLEASE NOTE: For the remaining provider practices (representing 20% of our enrollee population), we provide access to training resources through our online provider portal: (Click Here), and open discussions or trainings during our Provider Advisory Committee meeting.	Elaine Ellis Center of Health - Meetings held on: 11/01/2025 01/29/2025 - Meeting Focus: - Introductions - Review of the provider’s specific EPSDT CMS 416 participation ratios. - Best ways to increase participation results. - Use of Mobile Unit - Review of Wellness Clinic Days and future events. - Review of outreach efforts - Co-Location of outreach representative at clinic. - Outcome: - Clinic and mobile unit tour - Established mobile unit for future school events. - Introduction of Wellness Dental Days	Children’s Peds and Associates.: - Meeting held on: 04/01/2025 06/03/2025 - Meeting Focus: - Introduction of any new contacts. - Review of the provider’s specific EPSDT CMS 416 participation ratios for FY2025. - Outreach efforts review - Collaboration opportunities - Outcome: - To be determined during ongoing discussions - Next Steps: - Gap analysis review - Planning for FY2026	Children’s Peds and Associates.: - Meeting held on: 07/01/2025 08/05/2025 08/12/2025 - Meeting Focus: - Introduction of any new contacts. - Review of the provider’s specific EPSDT CMS 416 participation ratios for FY2025. - Lead panel review - Outreach efforts review - Outcome: - To be determined during ongoing discussions - Next Steps: - Continued gap analysis review

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		Topics and activities on the agenda for these meetings may include: - Sharing of provider specific EPSDT CMS 416 participant ratio performance with the top providers based upon their panel size (# of assigned enrollees). We calculate the provider-specific participant ratio based upon the # of children on the provider's panel with a valid well child visit/claim on record divided by the # of enrollees on the provider's panel. - Discussing opportunities to improve their participant ratios. - Exchanging data to optimize outreach efforts. This would include sharing information and outcomes for those families already called by AmeriHealth in a given month, those enrollees called by the provider in a given month, those enrollees who have missed appointments in a given month, and other relevant information. - Discussing opportunities to assist those guardians with multiple children in the household who have or have had difficulty scheduling appointments due to limitations imposed by the provider's scheduling department. In some cases, providers have limited the ability for large families to schedule because of the potential impact on their overall daily schedule if any of those families end up as "no shows".	- Next Steps: - Scheduling future meetings and trainings with Community Outreach team to have representatives located at their facility. - Scheduling future meetings to discuss opportunities for Wellness Clinic Events for Q3 and Q4. Children's Peds and Associates.: - Meeting held on: 11/19/2024 02/02/2025 03/12/2025 03/25/2025 - Meeting Focus: - Introduction of new contacts. - Review of the provider's specific EPSDT CMS 416 participation ratio for FY2024. - Best ways to increase results. - Claim turnaround time review. - Possibility for training on billing. - Establishing Wellness Clinic Days.	- Scheduling future meetings to discuss opportunities for Wellness Clinic Events. Elaine Ellis Center of Health - Meetings held on: 04/23/2025 - Meeting Focus: - Staff Introductions - Use of Mobile Unit for school events. - Review of Wellness Clinic Days and future events. - Co-Location of outreach representative at clinic. - Outcome: - Clinic and mobile unit tour for new staff. - Established mobile unit for future school events. - Wellness screening days outcomes. - Next Steps: - Establishing screening events for school sports clinics. - Gap analysis review	Unity Health Care: - Meetings held on: 07/08/2025 09/09/2025 - Meeting Focus: - Introduction of new staff. - Review of the provider's specific EPSDT CMS 416 participation ratio. - Ongoing training for their staff of the new EMR system. - Outcome: - Once training is complete, AmeriHealth looks to gain access and training of the new system. - Next Steps: - AmeriHealth looks to gain access and training of the new system. Elaine Ellis Center of Health - Meetings held on: 07/10/2025 - Meeting Focus:

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		NOTE: Based on discussions regarding families with 3 or more EPSDT eligible enrollees, we find that some provider groups have shown flexibility in opening their schedules to allow for the entire family to be seen or flexibility in their afternoon appointments. In those cases where the provider has agreed to allow us to schedule these large families together, we engage with the provider scheduling staff to schedule these appointments. Target Population: Enrollees Age: 0 – 20	○ Outcome: ○ To be determined during ongoing discussions ○ Next Steps: ○ Scheduling future meetings and trainings with Community Outreach team to have representatives located at their facility and system access for medical record review. ○ Scheduling future meetings to discuss opportunities for Wellness Clinic Events. Community of Hope: ○ Meetings held on: ○ 12/03/2024 ○ 01/30/2025 ○ 03/27/2025 ○ Meeting Focus: ○ Review of the provider’s specific EPSDT CMS 416 participation ratio for FY2024. ○ Best ways to increase results. ○ Establishing Wellness Clinic Days. ○ Continued member list reconciliation. ○ Outcome:	○ Planning for FY2026 C3 Cares: ○ Meeting held on: ○ 04/17/2025 ○ 05/15/2025 ○ 06/20/2025 ○ Meeting Focus: ○ Review of the provider’s specific EPSDT CMS 416 participation ratios for FY2025. ○ Outreach efforts review ○ Collaboration opportunities ○ Spring screening events. ○ Outcome: ○ Outreach opportunities to new patients who are non-compliant. ○ Screening events for the springtime. ○ Next Steps: ○ Discussion of opportunities for panel review of gaps in care and wellness screening events.	○ Staff Introductions ○ Use of Mobile Unit for school events. ○ Success of Wellness Clinic Days. ○ Access for outreach representative at clinic. ○ Outcome: ○ Continued outreach for future mobile unit school events. ○ Next Steps: ○ Continue establishing screening events for school sports clinics. ○ Gap analysis review ○ Planning for FY2026 C3 Cares: ○ Meeting held on: ○ 07/17/2025 ○ 08/27/2025 ○ 09/18/2025 ○ Meeting Focus: ○ Review of the provider’s specific EPSDT CMS 416 participation ratios for FY2025. ○ Outreach efforts review

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			○ To be determined during ongoing discussions. ○ Next Steps: ○ Scheduling future meetings to discuss opportunities for Wellness Clinic Events. Providence Health Service: ○ Meetings held on: ○ 12/03/2024 ○ Meeting Focus: ○ Introductions ○ Review of the provider's specific EPSDT CMS 416 participation ratios for FY2024 ○ Best ways to increase results. ○ Establishing Wellness Clinic Days ○ Co-Location of outreach representative at clinic. ○ Outcome: ○ Member reconciliation and panel review. ○ Outreach opportunities to new patients who are non-compliant. ○ Next Steps:	Unity Health Care: ○ Meetings held on: ○ 05/07/2025 ○ 06/11/2025 ○ Meeting Focus: ○ Introduction of new staff. ○ Review of the provider's specific EPSDT CMS 416 participation ratio. ○ Provider group panel and enrollee gap in care reconciliation. ○ Outcome: ○ Outreach opportunities to non-compliant patients who have continuously missed appointments. ○ Next Steps: ○ Scheduling future meetings to discuss opportunities for panel review of gaps in care. Children's National: ○ Meetings held on: ○ 05/20/2025 ○ Meeting Focus:	○ Wellness Day areas of opportunity. ○ In school screening events. ○ Outcome: ○ Outreach opportunities to new patients who are non-compliant. ○ Screening events for future quarter. ○ Next Steps: ○ Discussion of opportunities for future screening events for the summer. Community of Hope: ○ Meetings held on: ○ 07/24/2025 ○ 09/25/2025 ○ Meeting Focus: ○ Review of the provider's specific EPSDT CMS 416 participation ratio for FY2025. ○ Best ways to increase results. ○ Establishing Wellness Clinic Days.

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			○ Scheduling future meetings to discuss opportunities for Wellness Clinic Events for Q3 and Q4. Children’s National: ○ Meetings held on: ○ 10/23/2024 ○ 02/05/2025 ○ 02/18/2025 ○ 03/18/2025 ○ Meeting Focus: ○ Introductions ○ Review of the provider’s specific EPSDT CMS 416 participation ratios for FY2024 ○ Best ways to increase results. ○ Establishing Wellness Clinic Days ○ Co-Location of outreach representative at clinic. ○ Review of mobile unit utilization and processes ○ Outcome: ○ Member reconciliation and panel review. ○ Outreach opportunities to new patients who are non-compliant.	○ Introductions of new staff. ○ Review of the provider’s specific EPSDT CMS 416 participation ratios for FY2025 ○ Best ways to increase results. ○ Outcome: ○ Outreach opportunities to new patients who are non-compliant. ○ Next Steps: ○ Scheduling future meetings to discuss opportunities for screenings and/or immunizations events. Community of Hope: ○ Meetings held on: ○ 05/22/2025 ○ Meeting Focus: ○ Review of the provider’s specific EPSDT CMS 416 participation ratio for FY2025. ○ Best ways to increase results.	○ Continued member list reconciliation. ○ Outcome: ○ To be determined during ongoing discussions. ○ Next Steps: ○ Gap analysis review ○ Planning for FY2026

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			○ Next Steps: ○ Scheduling future meetings to discuss opportunities for screenings and/or immunizations events. C3 Cares: ○ Meeting held on: ○ 02/13/2025 ○ 02/20/2025 ○ 03/20/2025 ○ Meeting Focus: ○ Introduction of any new contacts. ○ Best ways to increase results. ○ Establishing Wellness Clinic Days. ○ Upcoming Well Child Visit events for screenings and immunizations. ○ Well Child Visit event planning with KIPP Charter schools. ○ Outcome: ○ Outreach opportunities to new patients who are non-compliant. ○ Next Steps: ○ Discussion of opportunities for panel review of gaps in	○ Establishing Wellness Clinic Days. ○ Continued member list reconciliation. ○ Outcome: ○ To be determined during ongoing discussions. ○ Next Steps: ○ Gap analysis review ○ Planning for FY2026	

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			care and wellness screening events. Unity Health Care: ○ Meetings held on: ○ 02/27/2025 ○ 03/11/2025 ○ Meeting Focus: ○ Review of the provider's specific EPSDT CMS 416 participation ratios for Q1. ○ Provider group panel and enrollee gap in care reconciliation. ○ Outcome: ○ Outreach opportunities to non-compliant patients who have continuously missed appointments. ○ Next Steps: ○ Scheduling future meetings to discuss opportunities for panel review of gaps in care. Howard University Family Practice Plan ○ Meeting held on: ○ 03/31/2025 ○ Meeting Focus:		

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			○ Introduction of new contacts. ○ Review of the provider's specific EPSDT CMS 416 participation ratios for Q1. ○ Provider group panel and enrollee gap in care reconciliation. ○ Best ways to increase results. ○ Outcome: ○ Outreach opportunities to non-compliant patients who have continuously missed appointments. ○ Next Steps: ○ Scheduling future meetings to discuss opportunities for panel review of gaps in care.		
	Provider EPSDT CMS Participant Ratios	Objective: Reestablish EPSDT Wellness Days and block-scheduling opportunities with providers that have capacity to conduct well child visits for prescheduled enrollees. Expectation for these strategies is to streamline clinic operations, reduce missed opportunities for care, and support proactive outreach to close care gaps. With EPSDT Wellness Days, we look to enhance patient engagement and boost provider performance metrics.	Discussions have continued with providers who have the schedule and capabilities to provide Wellness Event Days. Below is a list of days and locations that were scheduled where immunizations and/or Well Child Visits were available: Q1: ○ Elaine Ellis:	Discussions have continued with providers who have the schedule and capabilities to provide Wellness Event Days. Below is a list of days and locations that were scheduled where immunizations and/or Well Child Visits were available:	Discussions have continued with providers who have the schedule and capabilities to provide Wellness Event Days. Below is a list of days and locations that were scheduled where immunizations and/or Well Child Visits were available:

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		Description: Block scheduling is where a provider blocks off all or part of a schedule for some of their practitioners on a given day for a particular MCO or entity’s enrollees. This action item includes: - Targeting those providers with the largest enrollee panels. At present, those are Unity, Children’s, Mary Center, Howard, Children’s Pediatrics & Associates. - Identifying opportunities to collaborate with other providers that have the capacity for special wellness days or block scheduling. Identifying and coordinating with dental providers that have capacity and are willing to do wellness days and block scheduling. Target Population: Enrollees Age: 0 – 20	- October 23rd Q2: - Elaine Ellis: - January 22nd - February 26th - March 26th - C3 Cares: - January - Tuesdays and Thursdays - February - Tuesdays and Thursdays - March - Tuesdays and Thursdays	Q3: - Elaine Ellis: - April 23rd - May 28th - June 25th - C3 Cares: - April - Tuesdays and Thursdays - May - Tuesdays and Thursdays - June - Tuesdays and Thursdays	Q4: - Elaine Ellis: - July 23rd - August 27th - September 24th - C3 Cares: - July - Tuesdays and Thursdays - August - Tuesdays and Thursdays - September - Tuesdays and Thursdays
	Community Outreach Support	Objective: Minimize gaps in care and increase screenings for enrollees who are due or overdue in care. Description:	Note: A successful contact means that an AmeriHealth representative spoke to someone in the household.	Note: A successful contact means that an AmeriHealth representative spoke to someone in the household.	Note: A successful contact means that an AmeriHealth representative spoke to someone in the household.

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		Execute calls monthly to the guardians of due and overdue enrollees. As part of these calls, if the guardian is willing, the Community Outreach Support Rep will attempt to: ○ Inform the guardian of the enrollee's need for a well child, dental visit and/or other screening based our records. ○ Educate the guardian on the importance of all of the recommended visits, services and screenings, including COVID-19 vaccinations and boosters based upon the age of the enrollee. ○ Provide information on the various options available to the enrollee for visits, screenings and vaccinations. ○ Transportation options ○ Telemedicine for well child visits ○ Weekend/evening hours and upcoming wellness days at their provider and other available providers, as appropriate to the situation) ○ Locations offering COVID-19 vaccinations and boosters to individuals of all ages. ○ Conduct a 3-way call with the guardian and the enrollee's PCP, PDP or an available	Q1 Calls: ○ Outreach Call Attempts: 18,530 ○ Successful Contact: 2,923 ○ Appointments Scheduled: 1,455 Q2 Calls: ○ Outreach Call Attempts: 14,925 ○ Successful Contact: 4,944 ○ Appointments Scheduled: 2,354	Q3 Calls: ○ Outreach Call Attempts: 18,490 ○ Successful Contact: 4,397 ○ Appointments Scheduled: 1,989	Q4 Calls: ○ Outreach Call Attempts: 20,882 ○ Successful Contact: 2,789 ○ Appointments Scheduled: 1,279

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		pediatrician or dentist, if the guardian would like to schedule a well child appointment or other EPSDT services for their child. Target Population: Enrollees Age: 0 – 20 PLEASE NOTE: Telephonic outreach is primarily conducted during the hours of 8am – 8pm, Monday through Friday. For unsuccessful contacts that occurred during the hours of 8am to 3pm, we conduct 2nd and 3rd attempts during the hours of 4pm to 8pm weekdays as well as 9am to 4pm on Saturdays. After the 3rd unsuccessful telephonic attempt, we send a generic letter to the guardian as indicated below. (A successful telephonic contact is when the enrollee answers the telephone call.)			
	Community Outreach Support	Objective: Make final attempts at contacting enrollees who have been deemed “unreachable”. Description: Send a generic letter to the guardians of those enrollees that we were unable to reach after two (2) telephonic attempts. The letter will include the following information: ○ Notification aiding with the coordination visits(s), screenings(s) and vaccination(s) for which the enrollee is due or overdue; and	Total Letters Sent: ○ Q1: 556 ○ Q2: 955	Total Letters Sent: ○ Q3: 792	Total Client Letters Sent: ○ Q4: 752

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		The AmeriHealth telephone numbers to call for questions and assistance in scheduling visits or services. Target Audience: Enrollees Age: 0 - 20 PLEASE NOTE: The purpose of these letters is to make final attempts at contacting enrollees who have been deemed “unreachable”. We do not have the means to track or report the efficacy of the attempt.			
Total Eligible Receiving at least One Initial or Periodic Screen	Member Engagement / Community Event	Objective: Participate and/or collaborate to organize school and community based (health related) activities that promote EPSDT Services Description: Participate and/or collaborate to organize school and community based (health related) activities that promote EPSDT Services as we become aware of them, or we identify a viable opportunity. The determination to participate will depend upon whether we have capacity to participate when the activity is occurring and whether we have determined that the school/organization/activity has the potential to yield significant results: - Every Kid Healthy Week - Back to School Health Fairs - Dental focused Health Fairs Target Population:	Children’s National - Meeting held on: 10/23/2024 - Meeting Focus: - Introductions - Access to Care in schools - Scope of Services - Use of mobile unit vs Health Center - Outreach efforts - Outcome: - Specialized outreach to noncompliant enrollees who utilize the school-based health center for care. - Scheduling future events for 2nd quarter - Next Steps:	KIPP DC Public Schools - Meeting held on: 04/08/2025 04/25/2025 - Meeting Focus: - Well Child screening and immunizations event for KIPP students. Ballou High School - Meeting held on: 04/11/2025 04/22/2025 06/13/2025 - Meeting Focus: - Introduction of contacts and staff.	Ron Brown Public Schools - Meeting held on: 08/26/2025 09/23/2025 - Meeting Focus: - Future events around EPSDT Education for students

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		Enrollees Age: 5-20	○ Scheduling future meetings to discuss opportunities for screenings and/or immunizations events. Howard University School of Dentistry ○ Meeting held on: ○ 03/19/2025 ○ Meeting Focus: ○ Introduction of contacts. ○ Best ways to increase participation ○ Establishing Dental Clinic Days. KIPP DC Public Schools ○ Meeting held on: ○ 03/11/2025 ○ Meeting Focus: ○ Introduction of new contacts. ○ Well Child Visit event planning with KIPP Charter schools.	○ Scheduling future meetings to discuss opportunities for screenings and/or immunizations events for students. ○ Co-Location of staff at school to assist with identifying students who are non-compliant AmeriHeath enrollees. Columbia Heights Educational Campus ○ Meeting held on: ○ 06/18/2025 ○ Meeting Focus: ○ Introduction of contacts. ○ Discussions planning for Sports physical screening events for Columbia Heights students and feeder schools.	

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	Marketing & Communications	Objective: Develop and execute communications and advertisements to promote the AmeriHealth \$50 Well Child Visit incentive gift cards. This incentive is offered to enrollees ages 9-20 encourage families to prioritize well child visits. Description:	Q1: - Social Media - Social media ads and postings were placed on the following channels: Facebook, Instagram, and Twitter	Q3: - Social Media - Social media ads and postings were placed on the following channels: Facebook, Instagram, and Twitter	Q4: - Social Media - Social media ads and postings were placed on the following channels: Facebook, Instagram, and Twitter

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		These communications and advertisements may include social media, digital advertising, print advertising, and radio promotions. Target Audience: All Enrollees PLEASE NOTE: Social Media content is available through FaceBook (Click Here) and Instagram (Click Here).	○ English ○ Total Reach: 974,252 ○ Total Impressions: 2,142,701 ○ Spanish ○ Total Reach: 55,463 ○ Total Impressions: 76,682 ○ Radio: ○ Radio One Activation October to December: ○ WKJS - 93.9fm ○ WMMJ - 93.9fm ○ WPRS - 104.1fm ○ Audacy Radio Stations October to December ○ EL ZOL-107.9fm ○ WPGC -95.5fm Q2: Social Media ○ Social media ads and postings were placed on the following channels: Facebook, Instagram, and Twitter	○ English ○ Total Reach: 624,985 ○ Total Impressions: 2,032,181 ○ Spanish ○ Total Reach: 691,701 ○ Total Impressions: 3,741,449 ○ Radio: ○ Radio One Activation April to June: ○ WKJS - 93.9fm ○ WMMJ - 93.9fm ○ WPRS - 104.1fm ○ Audacy Radio Stations April to June ○ EL ZOL-107.9fm ○ WPGC -95.5fm	○ English ○ Total Reach: 265,057 ○ Total Impressions: 548,030 ○ Spanish ○ Total Reach: 192,093 ○ Total Impressions: 282,383 ○ Radio: ○ Radio One Activation July to September: ○ WKJS - 93.9fm ○ WMMJ - 93.9fm ○ WPRS - 104.1fm ○ Audacy Radio Stations July to September ○ EL ZOL-107.9fm ○ WPGC -95.5fm

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			○ English ○ Total Reach: 1,022,221 ○ Total Impressions: 2,505,016 ○ Spanish ○ Total Reach: 824,758 ○ Total Impressions: 1,026,864 ○ Radio: ○ Radio One Activation January to March: ○ WKJS -93.9fm ○ WMMJ -93.9fm ○ WPRS -104.1fm ○ Audacy Radio Stations January to March ○ EL ZOL-107.9fm ○ WPGC -95.5fm		
Total Eligible Receiving at least One Initial or Periodic Screen	Marketing & Communications	Objective: Develop and execute communications and advertisements to promote EPSDT services across all age groups. Description: These communications and advertisements may include social media, digital advertising, print advertising, and radio promotions.	Please note: Expect to receive the detailed information in the first week of November. Information will be updated once received.	Please note: Expect to receive the detailed information in the first week of November. Information will be updated once received.	Please note: Expect to receive the detailed information in the first week of November. Information will be updated once received.

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		Target Audience: All Enrollees			
		Objective: Promote EPSDT services through the Quarterly Enrollee Newsletter. Description: The articles promoting these services will include information about the importance of these services and resources available to help guardians schedule appointments for these services. Target Audience: All Enrollees PLEASE NOTE: Enrollees are alerted of the newsletter (Click Here) availability via postcard (one mailed to each household) sent in the Fall, Winter, Spring and Summer of each year. The exact timing of each mailing and the associated “in-home” date varies depending on the production schedule for that newsletter.	Q1: - Newsletter Mail Date: 10/2024 - Key/Relevant Article: - Fall 2024 Enrollee Newsletter: Lead Screenings for Children Q2: - Newsletter Mail Date: 01/2025 - Key/Relevant Article: - Winter 2025 Enrollee Newsletter: 3 Reasons to Have Well-Child Visits	Q3: - Newsletter Mail Date: 05/2025 - Key/Relevant Article: - Spring 2025: Enrollee Newsletter: 6 Reasons to Say Yes to Childhood Vaccines.	Q4: - Newsletter Mail Date: 07/2025 - Key/Relevant Article: - Summer 2025: Enrollee Newsletter: Earn Gift Cards with the Healthy Rewards Program.
		Objective: Promote EPSDT services periodically in the Washington Informer. Description: The articles promoting these services will include information about the importance of these services and resources available to help	Q1: N/A	Q3: May 2025 – ‘Don’t wait to vaccinate: The importance of EPSDT and preventive care’	Q4: August 2025 - Supporting Children’s Behavioral

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		guardians schedule appointments for these services. Target Audience: All Enrollees	Q2: March 2025 ○ Don't Wait to Vaccinate: The Importance of EPSDT and Preventive Care	○ June 2025 – 'Preparing for Kindergarten with a Well-Child Visit'	Health Through Early Interventions

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MCO: HSCSN

FY24 Participant Ratio: 70%

FY25 Goal Participant Ratio: 80%

Quarterly Goals: Q1: 15% Q2: 30% Q3: 50% Q4: 75%

Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. 1 & 2	Qtr. 3	Qtr. 4
- WCV Participation - Preventive Dental - BLS	Improve Telephonic Outreach and Tracking to Enrollees	Objective: Engage membership and increase participation of enrollees that attend their Well-Child Visits (WCV), preventive dental visits, lead screenings, and immunizations through targeted telephonic outreach to enrollees who are due to fall out of compliance or already out of compliance. Description: HSCSN utilizes four (4) Care Navigation Support Associate staff dedicated solely to EPSDT enrollee. Staff attempt to reach enrollees to remind them when they are due or past due for EPSDT appointments, including preventive screenings (Well-Child Visits), preventive dental visits, required immunizations, and blood lead screenings. Outreach and Appointment Scheduling includes the following: - Call to Enrollee/Caregiver to assist with scheduling appointment(s). - Inform enrollees on the availability of telehealth services and how to access services per each provider's offerings. - Call to provider to schedule appointment(s) and/or confirm appointment(s) kept/not kept.	Outreach Calls Q1 – 2034 calls (+8% from FY24Q1) 1220 unique enrollees attempted contact - Reached Enrollee/Caregiver – 68% - Left VM – 18% - Disconnected – 7% - Hang Up – 4% - No Answer – 2% - Wrong Number - 1% Q2 – 1312 calls (-1 staff member for Q1) 1004 unique enrollees attempted contact - Reached Enrollee/Caregiver – 63% - Left VM – 24% - Disconnected – 6% - No Answer – 6% - Wrong Number - 1% Appointments Scheduled Q1 - Scheduled – 676 - Kept – 503 (74%) Q2 - Scheduled – 494	Outreach Calls Q3 – 1960 calls 1379 unique enrollees attempted contact - Reached Enrollee/Caregiver – 80% - Left VM – 15% - No Answer/Unable to Leave VM – 3% - Incorrect/Non-working Number - 2% Appointments Scheduled Q3 - Scheduled – 611 - Kept – 472 (77%) New Enrollee Outreach Calls Q3 – 137 enrollees Well Child Visits (WCV): 73 (53%) verified completed WCV within past 10 months 17 (13%) scheduled for an upcoming WCV within 60 days 47 (34%) referred to Care Management for additional care coordination efforts	Outreach Calls Q4 – 2562 calls 1886 unique enrollees attempted contact - Reached Enrollee/Caregiver – 73% - Left VM – 20% - No Answer/Unable to Leave VM – 5% - Incorrect/Non-working Number - 2% Appointments Scheduled Q4 - Scheduled – 672 - Kept – 553 (82%) New Enrollee Outreach Calls Q4 – 199 enrollees Well Child Visits (WCV): 92 (46%) verified completed WCV within past 10 months 32 (16%) scheduled for an upcoming WCV within 60 days 75 (38%) referred to Care Management for additional care coordination efforts Preventive Dental Visit (PDV):

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		4. Reschedule appointment(s) not kept when needed. 5. Care Management is notified of unsuccessful enrollee contacts or excessive appointment “no-shows.” Outreach data is tracked in a monthly EPSDT productivity dashboard to look at outreach successes and trends. Individual dashboards are reviewed with Care Navigation Support Associates during 1:1 meetings. Team data is discussed monthly in EPSDT Team Meetings and quarterly during Quality Initiative and Oversight meetings. Data analysis includes: - Correlations between call volume, call success, and appointment scheduling assistance. - Reporting of wrong numbers and incorrect contact information on file for enrollees. - Staff feedback on strategies to improve telephonic outreach.	- Kept – 366 (74%) Outreach projects Q1 Starting in December 2024, the EPSDT outreach team took primary responsibility for contacting all new enrollees within 30 days of HSCSN enrollment to invite them to the monthly New Enrollee Orientation (NEO) and assisting with WCV and preventive dental appointment scheduling to ensure new enrollees were connected with primary care preventive health services within 60 days of enrollment. December - Well Child Visits (WCV): 70% verified completed WCV within past 10 months 18% scheduled for an upcoming WCV within 60 days 12% referred to Care Management for additional care coordination efforts - Preventive Dental Visit (PDV): 33% verified completed PDV within past 4 months 18% scheduled for an upcoming PDV within 60 days 49% referred to Care Management for additional care coordination efforts	Preventive Dental Visit (PDV): 22 (16%) verified completed PDV within past 4 months 18 (13%) scheduled for an upcoming PDV within 60 days 97 (71%) referred to Care Management for additional care coordination efforts	29 (15%) verified completed PDV within past 4 months 33 (16%) scheduled for an upcoming PDV within 60 days 137 (69%) referred to Care Management for additional care coordination efforts

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			Q2 - Well Child Visits (WCV): 78% verified completed WCV within past 10 months 14% scheduled for an upcoming WCV within 60 days 8% referred to Care Management for additional care coordination efforts - Preventive Dental Visit (PDV): 29% verified completed PDV within past 4 months 14% scheduled for an upcoming PDV within 60 days 57% referred to Care Management for additional care coordination efforts		
- WCV Participation - Preventive Dental - BLS	Expand/Improve Marketing & Engagement Efforts	Objective: Expand and update marketing strategies to increase enrollee engagement, increase event participation, increase EPSDT and preventive health screening awareness, and utilize new outlets to reach enrollees. Description: After the PHE, HSCSN launched innovative ways to connect with our enrollees through hybrid engagement to include continuous evaluation of outreach methods to drive increased enrollees' participation. The Marketing & Communications team has identified additional avenues to connect with enrollees through community-based	Q1 – Q2 (present) Mailings: - Fall Newsletter - Winter Newsletter - Event Flyers (5) - Benefit Updates: - Wellness Gift Card - Imagine Pediatrics - EasyConnect Enrollee App - Phone Communications Text Messages: - Campaigns: 24 - Delivered: 82.5% - Undelivered: 17.3% - Opt-Out: 0.2%	Q3 Mailings: - Spring Newsletter - Event Flyers (4) - Benefit Updates: - Imagine Pediatrics - EasyConnect Enrollee App - Fitness Program - Paid Caregiver - VAB Home Modification Term Text Messages (One-Way): - Campaigns: 8 - Link Click-Through Rate: 19% - Opt-Out: 0.2%	Q4 Mailings: - Summer Newsletter - Event Flyers (2): - Back to School Flyer - Dr. McPherson Clinic Day Flyer Text Messages (One-Way): - Campaigns: 4 - Dr. McPherson Clinic Day - Sent: 4084 - Delivered: 3451 - Delivered rate: 84.50% - Youth Athletic Program - Sent: 4071 - Delivered: 3419 - Delivered rate: 83.98%

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		collaborations to implement creative messaging and call-to-action campaigns about the importance of EPSDT Screening. Continue to offer the use of hybrid activities and platforms for HSCSN events for increased accessibility. Updated website features for accessibility and increase the quantity and quality of enrollee-facing resources - Quarterly Newsletters - Automated calling - Automated mailing - One-way and two-way text messaging - Website Slider- information Call-Out Box	Two-Way Text Messages: Launched January 29th to enhance communication and engagement with enrollees - Hello, HSCSN Enrollee! Have you done your annual wellness visit this year? - Yes: 38 - Good news. You are on the path to maintaining good health! If you have any questions, please contact your Care Manager at 202- 467-2737 - No: 12 - An EPSDT Health Check is important for staying healthy and keeping your vaccinations up to date. Contact your Care Manager at 202- 467-2737 and schedule your next checkup today! - Other: 3 - Thank you for your response. Please contact us at 202-467-2737 to speak with a live representative. **Response Goal: - Tracking “No” responses to ensure appointments are scheduled and attended within a 3-month timeframe. Robo Call: - Campaigns: 22 % Answered/Voicemail: 67%	Two-Way Text Messages Dental: Hello HSCSN Enrollee! Have you visited the dentist this year? Yes: 96 No: 80 Delivered: 2348 Engagement Rate: 7% Gift Card Rewards: We noticed that you still have reward money to spend for completing your annual visits. Do you know how to use your HSCSN gift card? Yes: 2 No: 17 Delivered: 138 Engagement Rate: 14% Notable Campaign Success: - Two-Way Text Messaging led to better engagement with enrollees resulting in scheduled appointments and increased attendance with Mobile Clinic Days. - Website engagement rates increased as many enrollees drew interest to VAB pages. The next step is to consolidate all VAB’s into one section for ease of access and navigation	- Back to School - Sent: 4076 - Delivered: 3460 - Delivered rate: 84.89% - Safe Kids Survey - Sent: 58 - Delivered: 58 - Delivered rate: 100.00% Website - July - Sessions: 6987 - Engagement rate: 72.90% - August: - Sessions: 6832 - Engagement rate: 73.02% - September: - Sessions: 6429 - Engagement rate: 74.50%

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			% Unanswered/Disconnected: 33% Radio (Digital): - Programs- Clicks: 1775; CTR: 0.31% - Care Mgmt- Clicks: 2065; CTR: 0.46% - Appt. Reminder: Clicks: 1740; CTR 0:44% Radio (On-Air): - Total Spots: 546 - Broadcast Visits: 1296 (4% of website traffic) *Notable Campaign Success: Wellness Center Marketing to drive foot traffic and CM face-to-face visits. 13% increase in HSCSN visitors YOY to date 5% increase in overall event/program attendance *Process Measures (Programs & Events): Text Messages Delivery %: 83% Robo Calls Answered %: 51% Radio Ad Clicks: 1775 +Flyers, Social Media, Website HSCSN Programs: Result: 267 (45 Sessions) HSCSN Signature Events: Result: 91 (3 Events)		
WCV Participation	Increase Collaboration with Network	Description: In-person programming has historically been the best way to engage enrollees and HSCSN	Q1 Mobile Health Screening Event – partnership with Children’s National	Q3 Mobile Health Screening Event – partnership with	Q4 Mobile Health Screening Event – partnership with Children’s

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- Preventive Dental - BLS	Providers to Offer Exclusive Wellness Events for Enrollees	recognized a substantial decline in in-person event attendance, including online platforms. This year, HSCSN will aim to: - Transition to more in-person community wellness events available to HSCSN enrollees for check-ups, preventive dental services, immunizations, and blood-lead screenings - Increase participation at wellness events through enhanced engagement strategies based on feedback from enrollees: - Consistent timing for recurring events (ex: mobile clinic will always occur on the 2nd Tuesday of each month and traveling Mobile Unit Activity throughout the District of Columbia). - In-person programming (when possible) with partners in the communities where enrollees live or congregate - Increase community-based and grocery retail education series (Giant Foods, Food Jonezi, DC Health Living Well Program) - Increase engagement with educational institutions for Dental Health activities and forums.	Mobile Clinic and National Children's Center (NCC) - Mobile clinic postponed in Q1 due to staff shortages to manage clinic. Q2 - Mobile Health Screening Event – partnership with Children's National Mobile Clinic and National Children's Center (NCC) - February 18th – 2 enrollees seen for screenings - March 18th – 1 enrollee seen for screening	Children's National Mobile Clinic and National Children's Center (NCC) - April- 11 enrollees seen for screenings - May- 1 enrollee seen for screenings - June- 11 enrollees seen for screenings	National Mobile Clinic and National Children's Center (NCC) - July- 11 enrollees seen for screenings - August- 1 enrollee seen for screenings - August - Clinic Day with Dr. McPherson Primary Care Clinic 8 enrollees seen for screenings
WCV Participation	Wellness Incentives for	Description: In FY25 HSCSN began implementing updates to the current Wellness Gift Card Program to incentivize enrollees to attend EPSDT Well-	Q1 At the start of FY25 the incentive card activation rate was 50% for all active HSCSN enrollees.	Q3 Card activation rate was 61% at the end of FY25 Q3 +11% FYTD	Q4 Card activation rate was 62% at the end of FY25 Q3 +12% FYTD

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Preventive Dental	Preventive Services	Child Visits, preventive care dental appointments, and engage with Care Management. Enrollee compliance is rewarded with incentive funds on a reloadable gift card (not to exceed \$75 per enrollee per calendar year). Measures: % of enrollees that have activated their reloadable gift card – demonstrates overall engagement with the incentive plan - Quarterly incentive report that indicates total number of incentive-qualifying services, amount enrollee received in incentive funds for qualifying service, and YTD total funds each enrollee has received.	11/7/2024 – HSCSN Care Navigation conducted a training with Care Management and CSS staff to increase awareness of the Wellness Gift Card Program and coming updates. Updates included: - Simplifying the wellness goals from 5 categories to 3 - Increasing the incentive amount from \$15 per wellness goal to \$25 per goal - Adding gift card activation status (active/not active) and current card balance to all EPSDT outreach and care gaps lists dispersed to staff Total wellness goals awarded in FY25Q1 was 1580, which is 32% more than the total number of wellness goals awarded in FY24Q1 At the end of FY25 Q1 the incentive card activation rate was 55% (+5%) Q2 Card activation rate was 58% (+3%) at the end of FY25 Q2 HSCSN also saw an increase in overall card spending with an increase in reward redemption of 158% in FY25 Q2 compared to FY24 Q2	HSCSN has seen increases in card replacement, card load/reward load, and enrollee spend for 2025 YTD compared to same time in 202. This indicates increased enrollee engagement with and awareness of the reward plan: +150% increase in card replacement requests. +186% increase in card load due to increased individual reward amounts and simplification of health goals. +168% increase in enrollee spend.	29% of active cards utilized (at least one transaction) 481 replacement card requests processed (9% of enrollee population)

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WCV Participation	Collaborate with Providers to Close Care Gaps	Objective: To maintain provider network adequacy, enhance enrollee access to services, and bolster relationships with providers through health plan education. Also, utilize and support existing provider strategies to close enrollee care gaps related to EPSDT and preventive services. Description: 1. Identify network providers willing to participate in care gap data sharing. If providers are amiable to data sharing, review their existing outreach strategies to improve preventive service participation. 2. Utilize and support existing provider strategies to increase preventive service participation through data sharing. Generate enrollee care gap lists based on assigned PCP panel and share noncompliance lists with assigned provider 3. To improve data sharing strategies with providers, HSCSN is implementing a network provider portal for direct access to HSCSN enrollee information by treating providers	Q1 Monthly engagement with CN and CNPA providers in a workgroup to support care gap closer: • PowerCharts primary care appointment scheduling continued with 100% scheduling response within 5 business days of request submission – this has become the primary means of HSCSN appointment scheduling with CN and CNPA when assistance is requested by the enrollee or caregiver • CN updated clinic hours to include later appointment availability (until 7pm weekdays) and weekend availability (rotating Saturday availability). • CN Anacostia Clinic saw increases in appointment show rates for extended hour appointments*: ○ 11% increase in show rate for PCP newborn visits ○ 11% increase in show rate for 0-11 WCV ○ 23% increase in show rate for 12+ WCV ○ 10% increase in show rate for PCP FUP visits ○ The Anacostia Clinic also noted that 86% of extended hours encounters were with patients with Medicaid listed as the insurance type.	Q3 The cadence of the PHN workgroup has been decreased to quarterly. • No additional data on show-rates specific to extended hour and weekend appointments has been shared in the workgroup since Q1. Previous data was shared as a snapshot of initial appointment attendance outcomes after implementation of the updated schedules. • Continued interventions to help with appointment scheduling and follow-up: ○ PowerCharts is a messaging feature within the CN and CNPA scheduling system that allows authorized users to send appointment scheduling requests directly to the scheduling teams rather than calling through the appointment line. Once CN or CNPA receives the request they schedule an	Q4 Provider Portal HSCSN's Provider Portal is now live! Effective September 15, 2025, HSCSN partnered with Availity as the access point for the portal, in which providers can verify claims status, real-time enrollee eligibility and benefits and submit online authorizations. HSCSN partnered with HealthEdge to manage the Authorization portal. Providers are able to access both portals with single sign-on capabilities.

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				appointment and confirm the information directly with the enrollee or family. This allows HSCSN staff to work more efficiently to schedule multiple appointments for families. ○ Enrollees can still schedule their own appointments through the CN app if they have a smartphone or their CN account if they have access to a computer. The system all sends appointment reminder emails and texts from the provider. ○ HSCSN receives a report each week with all enrollee appointments for the upcoming two weeks to allow outreach staff to verify upcoming appointment details. HSCSN also receives a	

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				report at the beginning of each week indicating appointment outcomes (kept, missed, rescheduled, etc.) for all enrollee appointments from the previous week. Provider Portal Portal project still in testing for projected implementation in FY26. Follow-up items: As part of ongoing efforts to engage with enrollees using school-based health centers (SBHC), HSCSN collaborated with representatives from all SBHC providers (Children’s National, Unity, and Medstar) to create a referral system. SBHC could notify HSCSN if an enrollee was seen in a SBHC to engage the Care Manager for follow-up assistance. To date, HSCSN has received zero referrals follow-up.	

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- WCV Participation - Preventive Dental - BLS	Enrollee Engagement with Care Management	Description: HSCSN has implemented efforts in FY25 to improve and enhance enrollee engagement with the health plan through revised Care Management (CM) engagement metrics and the release of a new mobile app. The EASY Connect app launched in December 2024 as a new outlet of enrollee engagement and education. Measures: - Care Management Engagement – metric tracking successful 2-way engagement with an enrollee or caregiver (total engagement), successful completion of a face-to-face (F2F) visit (virtual included), and successful update of the enrollee’s Care Plan (CP) - EASY Connect app activation	Q1 Enrollee Engagement metrics at the end of Q1 - Total Engagement – 76% - F2F – 67% - CP – 63% December EasyConnect App Activation: - Staff Invites: 15 - Staff Onboards: 1 - Self Onboards (via Marketing Campaigns): 24 - Total Onboards: 25 Q2 Enrollee Engagement metrics at the end of January - Total Engagement – 73% - F2F – 66% - CP – 63% January EasyConnect App Activation: - Staff Invites: 40 - Staff Onboards: 7 - Self Onboards (via Marketing Campaigns): 6 - Total Onboards: 13 February EasyConnect App Activation: - Staff Invites: 66 - Staff Onboards: 17 - Self Onboards (via Marketing Campaigns): 3 - Total Onboards: 20	Q3 Enrollee Engagement metrics at the end of Q3 - Total Engagement – 82% - F2F – 71% - CP – 64% These metrics are representative of all HSCSN enrollees regardless of app involvement. Q3 EasyConnect App Activation: - Staff Invites: 217 - Staff Onboards: 39 - Self-Onboards (via Marketing Campaigns): 2 Total Onboards: 41	Q4 Enrollee Engagement metrics at the end of Q4 - Total Engagement – 85% - F2F – 78% - CP – 74% These metrics are representative of all HSCSN enrollees regardless of app involvement. Q4 EasyConnect App Activation: - Staff Invites: 141 - Staff Onboards: 29 - Self-Onboards (via Marketing Campaigns): 7 Total Onboards: 177

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- WCV Participation - Preventive Dental - BLS	Addressing Unable to Reach (Un-engaged) Enrollees	HSCSN serves individuals with significant health and social service needs and we must be able to locate and contact these individuals before we can effectively serve them. Additionally, contact information must be updated frequently because some of our enrollees have unstable housing situations or use prepaid cell phones that run out of minutes. As a result, we face challenges consistently reaching and serving our enrollees in a timely way. Unfortunately, we often are unable to reach eligible enrollees due to the receipt of inaccurate contact information or disengagement. 1. Compile a list of <i>un-engaged enrollees</i> defined as an enrollee who meets all below criteria: a. No practitioner or hospital visits in >6 months, b. No Face-to-Face Visit in >6months, c. No Care Plan developed in > 6 months, d. No Assessment Completed in > 6 months, e. No Successful Contact by Phone in > 6 months, f. No other 2-way communication documented – Other 2-way communications may be emails or texts that are sent by an HSCSN Care	Q1 In Q1, HSCSN focused efforts on our Unable to Contact Process. These efforts yielded increased numbers identified as Unable to Contact. This is because our approach is proactive and to place enrollees into the first program after the 4th unsuccessful outreach attempt. Because of this we expect enrollees to move into this program, but transition successfully out of the programs as we engage with them. This approach will limit the time enrollees are not engaged as, once identified, the outreach efforts become more frequent and include unscheduled in-person visits. Care Management centralized the nonclinical staff (Care Support Specialists) and have them on rotations to optimize phone outreach, record reviews, and attempt unannounced visits to the last known addresses on a daily basis. Care Management is also engaging on a data clean up efforts to ensure the UTC programs are only open for those unable to be <i>located</i>. The CSS staff and CMs attempt to schedule WCV, preventative dental, lead screenings, and close any other care gaps that are identified. Caregivers often focus on urgent issues to be resolved at the time of contact but staff make efforts to close gaps if able. The goal to re-engage enrollees back into a regular timeline of care	Q3 The number of enrollees at the end of Q3 in the escalating stages of our Unable to Contact (UTC) processes were: - UTC 1- 204 - UTC 2- 153 - UTC 3- 19 - Total: 376 These phases indicate the activities included in reengaging enrollees: UTC 1 utilizing calls; UTC 2 including record reviews, unannounced visits, calls, letters; UTC 3 engaging supervisory review of the above efforts to verify enrollees meet the criteria to be considered “un-engaged” prior to disenrollment submission. The enrollee counts in each program changes daily as enrollees are reengaged or unable to be contacted during scheduled outreach intervals, prompting the start of the focused efforts as soon as possible to minimize disengagement with the Care Manager and preventative care.	Q4 The number of enrollees at the end of Q4 in the escalating stages of our Unable to Contact (UTC) processes were: - UTC 1- 164 - UTC 2- 142 - UTC 3- 19 - Total: 325

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		Manager (or other employee) and has a response from the enrollee 2. Utilize support staff to review records to determine if enrollees accurately meet criteria. 3. Employ innovative outreach strategies beyond mailings, phone call attempts, and/or door hangers a. Identify current providers from claims and prior authorization data (Dental, Physical Health, Behavioral Health, Pharmacy, etc.) b. Maximize community partnerships and existing relationships c. Attend known scheduled medical appointments d. Send health plan staff into the community e. Leverage the enrollee's personal support network f. Flag unable to reach enrollees	coordination engagement to meet preventive health goals. October 479 enrollees November 371 enrollees December - Due to a data configuration update, the data for December is unavailable but will resume with January 2025 data. January 413 enrollees February 445 enrollees March 502 enrollees		
- WCV Participation - Preventive Dental - BLS	Addressing Benefit Eligibility; Initial SSI Applications and Redeterminations as well	EPSDT is a critical component of Medicaid for children, ensuring they receive preventive, diagnostic, and necessary treatment services. We work to help ensure active SSI/Medicaid eligibility and HSCSN enrollment as a child's Medicaid eligibility is what grants them access to EPSDT services and care management aimed at improving participant ratios.	Q1 Between October 2024 and December 2024 369 HSCSN Enrollees received outreach services that focused on SSI redetermination and Medicaid recertification education and requirements as well as verifying the eligibility status of each benefit.	Q3 Between April 2025 and June 2025, 170 HSCSN Enrollees received outreach services that focused on SSI redetermination and Medicaid recertification education and requirements as well as verifying the eligibility status of each benefit.	Q4 Between July 2025 and September 2025, 398 HSCSN Enrollees received outreach services that focused on SSI redetermination and/or Medicaid recertification education and requirements as well as verifying the eligibility status of each benefit.

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	as Medicaid Renewals with no gap in Coverage.	The HSCSN Eligibility and Benefits Coordinator will: - Collaborate with SSA, ESA and the Office of Health Care Ombudsman to assist Enrollees in navigating their benefits and taking the necessary actions to prevent loss of coverage and CASSIP disenrollment. - Monitor and track upcoming disenrollments via the 834 and - Verify eligibility and type of recertification or redetermination required for each Enrollee by using the DC.gov Medicaid Portal Additionally, HSCSN will outreach to: - Alert Enrollees of upcoming renewal/redetermination dates. - Assist with the completion of Medicaid renewal forms and the SSI redetermination process. - Encourage Enrollees to use District Direct to report updated demographic information to help ensure they receive timely benefit/coverage information. - Work to help ensure continuity of care through active SSI/Medicaid eligibility and HSCSN enrollment for access to EPSDT services and care management aimed at improving participant ratios.	- The Eligibility and Benefits Coordinator made outreach attempts to 100% of Enrollees at least 30 days prior to eligibility end date. - Assisted 358 Enrollees with Medicaid renewals. - Assisted 38 Enrollees with SSI redeterminations. HSCSN continues to manually track, and update enrollee records based on available eligibility data. Q2 Between January 2025 and March 2025 207 HSCSN Enrollees received outreach services that focused on SSI redetermination and Medicaid recertification education and requirements as well as verifying the eligibility status of each benefit.	- The Eligibility and Benefits Coordinator made outreach attempts to 100% of Enrollees at least 30 days prior to eligibility end date. - Assisted with 191 Medicaid renewals. - Assisted with 269 SSI redeterminations. HSCSN continues to manually track, and update enrollee records based on available eligibility data.	- The Eligibility and Benefits Coordinator made outreach attempts to 100% of Enrollees at least 30 days prior to eligibility end date. - Assisted with 192 Medicaid renewals. - Assisted with 258 SSI redeterminations. - Assisted with 4 initial SSI applications HSCSN continues to manually track, and update enrollee records based on available eligibility data

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Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. 1 & 2	Qtr. 3	Qtr. 4

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MCO: MedStar Family Choice DC (MFC)

FY ‘24 Participant Ratio: 53%

FY ‘25 Goal Participant Ratio: 80%

Quarterly Goals: Q1: 13% Q2: 10% Q3: 30% Q4: 30%

Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. & 2	Qtr. 3	Qtr. 4																																																																																						
Total EPSDT Eligible Enrollees Receiving At Least One Initial or Periodic Well-Child Visit (WCV)	WCV	Well-Child Visit (WCV) Compliance Objective: - To increase compliance for Enrollees due and overdue for WCVs. - To address barriers to care, such as lack of transportation and language barriers. Description: EPSDT Outreach Coordinators are provided a monthly EPSDT outreach call list of Enrollees that are due/overdue for WCV, preventative dental visits, lead screening, and immunizations. Outreach staff are also provided with a list of Enrollees who are due for EPSDT preventive care visits for the next month for proactive outreach. Outreach coordinators will provide: - Assistance with scheduling appointment(s). - Education about the importance of WCVs.	Q1 - 10/1/2024-12/31/24	Q3 - 4/1/2025-6/30/25	Q4- 7/1/2025-9/30/2025																																																																																						
			<table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Call attempts* Totals</td><td>10,377</td></tr><tr><td>October</td><td>4,178</td></tr><tr><td>November</td><td>2,836</td></tr><tr><td>December</td><td>3,363</td></tr><tr><td>Successful contacts*</td><td>2,407</td></tr><tr><td>October</td><td>1,023</td></tr><tr><td>November</td><td>652</td></tr><tr><td>December</td><td>732</td></tr><tr><td>Voicemails*</td><td>3,574</td></tr><tr><td>October</td><td>1,493</td></tr><tr><td>November</td><td>892</td></tr><tr><td>December</td><td>1,189</td></tr><tr><td>Appointments scheduled*</td><td>680</td></tr><tr><td>October</td><td>194</td></tr></table>	Measure	Outcome	Call attempts* Totals	10,377	October	4,178	November	2,836	December	3,363	Successful contacts*	2,407	October	1,023	November	652	December	732	Voicemails*	3,574	October	1,493	November	892	December	1,189	Appointments scheduled*	680	October	194	<table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Enrollees (Overdue)</td><td>1,194</td></tr><tr><td>Call attempts* Totals</td><td>3,630</td></tr><tr><td>April</td><td>2,038</td></tr><tr><td>May</td><td>929</td></tr><tr><td>June</td><td>663</td></tr><tr><td>Appointments scheduled*</td><td>98</td></tr><tr><td>April</td><td>13</td></tr><tr><td>May</td><td>51</td></tr><tr><td>June</td><td>34</td></tr><tr><td>Appointments Completed</td><td>40</td></tr><tr><td>April</td><td>4</td></tr><tr><td>May</td><td>12</td></tr><tr><td>June</td><td>24</td></tr></table>	Measure	Outcome	Enrollees (Overdue)	1,194	Call attempts* Totals	3,630	April	2,038	May	929	June	663	Appointments scheduled*	98	April	13	May	51	June	34	Appointments Completed	40	April	4	May	12	June	24	<table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Enrollees (due)</td><td>139</td></tr><tr><td>Call attempts* Totals</td><td>4971</td></tr><tr><td>July</td><td>1314</td></tr><tr><td>August</td><td>1547</td></tr><tr><td>September</td><td>2110</td></tr><tr><td>Appointments scheduled*</td><td>335</td></tr><tr><td>July</td><td>97</td></tr><tr><td>August</td><td>119</td></tr><tr><td>September</td><td>119</td></tr><tr><td>Appointments Completed</td><td>47</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>46</td></tr><tr><td>September</td><td>1</td></tr></table>	Measure	Outcome	Enrollees (due)	139	Call attempts* Totals	4971	July	1314	August	1547	September	2110	Appointments scheduled*	335	July	97	August	119	September	119	Appointments Completed	47	July	0	August	46	September	1
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		- Information to Enrollees about available appointments (or telehealth services). - Daily targeting pediatric Enrollees who went to ER within 48 hours to any hospitals. - Scheduling well child visit when following up on ER visit. - Verifying completion of appointments scheduled. - Appointment reminders at least 3 days prior to the scheduled appointment. - Assistance arranging transportation to/from appointments as needed. Additionally, EPSDT Outreach Coordinators call provider offices to confirm if the Enrollee’s scheduled appointment was completed or not and contact Parents/Guardians/Enrollees to reschedule missed appointments. The data for verified appointments includes completed appointments/verification of appointments scheduled by Enrollee or provider (Q1). Going forward appointment verified will be completed appointments during the quarter. Q2 reflects appointments scheduled and completed. Note, in FY2024, we made extra efforts to ensure the demographic accuracy of this	<table><tr><td>November</td><td>376</td></tr><tr><td>December</td><td>110</td></tr><tr><td>Appointments verified*</td><td>677</td></tr><tr><td>October</td><td>248</td></tr><tr><td>November</td><td>173</td></tr><tr><td>December</td><td>256</td></tr><tr><td>Engagement rate*</td><td>23%</td></tr></table>	November	376	December	110	Appointments verified*	677	October	248	November	173	December	256	Engagement rate*	23%		<table><tr><td>Engagement rate*</td><td>4%</td></tr></table> Reorganization on reporting during mid-year. We will have year over year reporting going forward. Due/overdue or combination of the two will be clarified going forth.	Engagement rate*	4%	<table><tr><td></td><td></td></tr><tr><td colspan="2"></td></tr><tr><td>Enrollees (Overdue)</td><td>42</td></tr><tr><td>Call attempts* Totals</td><td>2239</td></tr><tr><td>July</td><td>527</td></tr><tr><td>August</td><td>514</td></tr><tr><td>September</td><td>1198</td></tr><tr><td>Appointments scheduled*</td><td>180</td></tr><tr><td>July</td><td>40</td></tr><tr><td>August</td><td>43</td></tr><tr><td>September</td><td>97</td></tr><tr><td>Appointments Completed</td><td>49</td></tr><tr><td>July</td><td>27</td></tr><tr><td>August</td><td>18</td></tr><tr><td>September</td><td>4</td></tr></table>					Enrollees (Overdue)	42	Call attempts* Totals	2239	July	527	August	514	September	1198	Appointments scheduled*	180	July	40	August	43	September	97	Appointments Completed	49	July	27	August	18	September	4
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		list of members to ensure best outcomes for this activity. *Definitions: <u>Due:</u> Enrollees due for well-child visit based on DOB <u>Overdue:</u> Enrollees who are more than 45 days overdue for a well-child visit. <u>Call Attempts:</u> Coordinator makes calls to Enrollees <u>Successful Contacts:</u> Coordinator spoke with Enrollee/Parent/Guardian <u>Voicemails:</u> Coordinator left a voicemail for the Enrollee after an unsuccessful contact <u>Appointments Scheduled:</u> Coordinator assists with scheduling appointment(s) <u>Completed Appointments:</u> Coordinator contacts PCP to verify completion of scheduled appointment(s). Includes wellness day completed appointments. <u>Engagement Rate:</u> Successful contacts divided by call attempts	<table><tr><td>January</td><td>705</td></tr><tr><td>February</td><td>685</td></tr><tr><td>March</td><td>860</td></tr><tr><td>Appointments scheduled*</td><td>145</td></tr><tr><td>January</td><td>70</td></tr><tr><td>February</td><td>41</td></tr><tr><td>March</td><td>34</td></tr><tr><td>Completed Appointments*</td><td>37</td></tr><tr><td>January</td><td>12</td></tr><tr><td>February</td><td>10</td></tr><tr><td>March</td><td>15</td></tr><tr><td>Engagement rate*</td><td>23%</td></tr></table>			January	705	February	685	March	860	Appointments scheduled*	145	January	70	February	41	March	34	Completed Appointments*	37	January	12	February	10	March	15	Engagement rate*	23%		
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Total EPSDT-Eligible Enrollees Receiving At least One Initial or Periodic WCV/Dental Visit/Immunizations	WCV/Dental Visit/Immunization on Scheduling and Compliance	Vendor Outreach for EPSDT Services Objective: To increase compliance for Enrollees due and overdue for WCVs.	Q1 - 10/1/2024-12/31/24 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td colspan="2">HCDI</td></tr><tr><td>Call attempts*</td><td>9,370</td></tr></table>			Measure	Outcome	HCDI		Call attempts*	9,370	Q3 - 4/1/2025-6/30/25 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td colspan="2">HCDI</td></tr><tr><td>Call attempts*</td><td>105</td></tr></table>	Measure	Outcome	HCDI		Call attempts*	105	Q4- 7/1/2025-6/30/2025												
Measure	Outcome																														
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Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. & 2			Qtr. 3			Qtr. 4		
		- Outreaching Enrollees who are “Unable To Reach” - To address barriers to care, such as language barriers and lack of transportation. - Reducing disparities in health, promote effective communication and preventative care. Description: - MedStar Family Choice DC has contracted with V-Tech, a Certified Business Enterprise (CBE), for community-based “boots on the ground” (in person face-to-face attempt) efforts to engage our Enrollees who are due/overdue for EPSDT Services. - V-Tech adjusted their schedule to include extended hours during the week for evening contact attempts and similar efforts on Saturdays to Enrollees who are unable to reach. “Unable to Reach” are Enrollees who are due/overdue for services.	October	3,829		June	105				
			November	2,683		Successful contacts*	62			Measure	Outcome
			December	2,858						HCDI	
			Successful contacts*	4,153		June	62			Call attempts*	6076
			October	1,601		Appointments scheduled*	0			July	4286
			November	1,109		June	0			August	1514
			December	1,443						September	276
			Appointments scheduled*	30		V-Tech				Successful contacts*	
						Face-to-face attempts*	1,246			July	780
			October	15		April	804			August	137
			November	3		May	442			September	37
			December	12		Successful contacts	33			Appointments scheduled*	25
			Engagement rate*	44%		April	23			July	0
						May	10			August	20
			V-Tech			Scheduled Appointments	2			September	5
			Face-to-face attempts*	2,529		April	3			Face to Face: 115	
			October	740		May	2				
			November	909						V-tech	
										Face-to-face attempts*	
										April	
										May	

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		An Enrollee is defined as “Unable-to-Reach when they do not respond to three (3) consecutive contact attempts (such as not answering calls, no Enrollee follow-up after a voicemail has been left, or call efforts have noted a lack of voicemail option. Enrollees are also categorized as “Unable-to-Reach,” if telephonic contact is unsuccessful due to an incorrect phone number, a lack of phone number, or a disconnected phone number. • CHOR (Community Help Outreach Worker) Document accurate outreach outcomes and status on real-time basis. • Compile unreachable Enrollees in a list; report to MFC-DC EPSDT monthly. • CHOR will do face-to-face community outreach to all hard to-reach Enrollees which includes home visits and participation in wellness days for well-child visits and dental care.	December	880			Successful contacts		
			Successful contacts	160			April		
			October	53			May		
			November	64			Scheduled Appointments		
			December	43			April		
			Scheduled Appointments	7			May		
			October	2			**V-Tech: Process of terminating the contract during Q4. Currently in negotiation and because of this no numbers reported for Q4.		
			November	4					
			December	1					
			Engagement rate*	6%					
			Q2 - 1/1/2025-3/31/2025						
			Measure	Outcome					
			HCDI						
			Call attempts*	2,375					
			January	2,375					
			February	0					

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Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. & 2			Qtr. 3	Qtr. 4
		- January and March, the scope of work for CBE was reviewed to ensure it aligns with MedStar Family Choice DC needs. - MedStar Family Choice DC is also partnering with Geddie Group (HCDI) a CBE, for calls to EPSDT Enrollees that are due/overdue for WCVs and/or preventive dental care. - These efforts will include: “Welcome calls” (HRA and SDOH (social determinants of health) assessments will be included. - This report identifies Enrollees of all ages that have been screened for Social Determinants Of Health (SDOH) or health-related social factors using the DHCF minimum set of SDOH questions. - Receive weekly reports from HCDI. - February and March, the scope of work for CBE was reviewed to ensure it aligns with MedStar Family Choice DC needs.	Successful contacts* 1,142				
			January	1,142			
			February	0			
			Scheduled Appointments	0			
			Engagement rate*	48%			
			V-TECH				
			Face-to-face	1,495			
			January	718			
			February	777			
			Successful contacts	92			
			January	45			
			February	47			
			Scheduled Appointments	5			
			January	0			
			February	5			
			March	0			
			Engagement rate*	6%			

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Total EPSDT-Eligible Enrollees Receiving At Least One Initial or Periodic WCV Screening, dental services and immunizations	WCV/Dental/Immunization	Enrollee Educational Materials Objective: To increase Enrollees’ knowledge of the significance of going to EPSDT well-child visit, preventive care dental visits and immunizations. Increase the accessibility of printed instructive materials related to EPSDT measures. Description: EPSDT coordinators will disburse approved educational materials to Enrollees at upcoming wellness events. For instances when Enrollees are not well-informed about the benefits available to them, EPSDT coordinator has an opportunity to communicate Enrollee compliance and reply to common questions when Enrollee is face-to-face.	All approved EPSDT educational material is housed internally for EPSDT Coordinators disbursement for upcoming wellness events. - Well-child visits matter! - Dental health checks matter! *Educational Material Attached 	Q3 - 4/1/2025-6/30/25 FY2025 Q4 will provide tracking on how much literature was distributed during community events	Q4 7/1/2025-9/30/2025 July-12 August-44 September-22 Total-78 Educational Materials

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Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. & 2	Qtr. 3	Qtr. 4																												
Total EPSDT-Eligible Enrollees Receiving At Least One Initial or Periodic WCV Screening	WCV/Dental/Immunization	EPSDT Outreach by Mail (Letters) Objective: To educate and engage parents/guardians/Enrollees who are due and overdue for WCV/Dental Visits/Immunizations Description: The letter also includes information about required well child visit, dental and immunization if needed, how to obtain transportation and scheduling assistance through the MFC-DC Outreach Department. We will incorporate with EPSDT coordinators to inquire how they received the information	Q1: 10/1/2024-12/31/2024 & Q2: 1/1/2025-3/31/2025 MFC-DC will start mailing letters out in the middle of Quarter 3.	Q3 - 4/1/2025-6/30/25 WCV/Dental/Immunization Mailed: 79 Letters	Q4 7/1/2025-9/30/2025 WCV/Dental/Immunization Mailed: 194 Letters																												
Total EPSDT-Eligible Enrollees Receiving Periodic Dental Screening	Dental	EPSDT Preventive Dental-Focused Telephonic Outreach and Appointment Scheduling Description: EPSDT Outreach Coordinators make calls to parent/ guardian/Enrollees that are due and overdue for preventive dental visits. Actions:	Q1 10/1/2024-12/31/24 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Call attempts* Totals</td><td>4,697</td></tr><tr><td>October</td><td>1,917</td></tr><tr><td>November</td><td>1,310</td></tr><tr><td>December</td><td>1,470</td></tr></table>	Measure	Outcome	Call attempts* Totals	4,697	October	1,917	November	1,310	December	1,470	Q3 - 4/1/2025-6/30/25 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Enrollees (Overdue)</td><td>451</td></tr><tr><td>Call attempts* Totals</td><td>2,216</td></tr><tr><td>April</td><td>777</td></tr><tr><td>May</td><td>765</td></tr></table>	Measure	Outcome	Enrollees (Overdue)	451	Call attempts* Totals	2,216	April	777	May	765	Q4 7/1/2025-9/30/2025 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Enrollees (Overdue)</td><td>18</td></tr><tr><td>Call attempts* Totals</td><td>37</td></tr><tr><td>July</td><td>0</td></tr></table>	Measure	Outcome	Enrollees (Overdue)	18	Call attempts* Totals	37	July	0
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		Parents/Guardian/Enrollees are called and provided education about the importance of annual dental visits and are offered assistance with appointment scheduling • EPSDT Outreach Coordinators can arrange transportation to/from appointments, as needed • Coordinators call Enrollees to remind them of upcoming appointments at least 3 days prior • Following the appointment, Coordinators call provider offices to confirm if the Enrollee’s scheduled appointment was completed or not, and contact Parents/ Guardians/ Enrollees to reschedule any missed appointments * The data for verified appointments includes completed appointments/verification of appointments scheduled by Enrollee or provider (Q1). Going forward appointment verified will be completed appointments during the quarter. Q2 reflects appointments scheduled and completed. *Definitions: <u>Due/Overdue:</u> Enrollees has not completed a dental screening in 6 months or more than 6 months overdue for dental screening. <u>Call attempts:</u> Coordinator makes calls to Enrollees	<table><tr><td>Successful contacts*</td><td>1,040</td></tr><tr><td>October</td><td>415</td></tr><tr><td>November</td><td>296</td></tr><tr><td>December</td><td>329</td></tr><tr><td>Voicemails*</td><td>1,316</td></tr><tr><td>October</td><td>524</td></tr><tr><td>November</td><td>382</td></tr><tr><td>December</td><td>410</td></tr><tr><td>Appointments scheduled*</td><td>156</td></tr><tr><td>October</td><td>65</td></tr><tr><td>November</td><td>43</td></tr><tr><td>December</td><td>48</td></tr><tr><td>Completed Appointments*</td><td>64</td></tr><tr><td>October</td><td>23</td></tr><tr><td>November</td><td>24</td></tr><tr><td>December</td><td>17</td></tr><tr><td>Engagement rate*</td><td>22%</td></tr></table> Q2: 1/1/25-3/31/2025	Successful contacts*	1,040	October	415	November	296	December	329	Voicemails*	1,316	October	524	November	382	December	410	Appointments scheduled*	156	October	65	November	43	December	48	Completed Appointments*	64	October	23	November	24	December	17	Engagement rate*	22%	<table><tr><td>June</td><td>674</td></tr><tr><td>Appointments scheduled*</td><td>44</td></tr><tr><td>April</td><td>9</td></tr><tr><td>May</td><td>15</td></tr><tr><td>June</td><td>20</td></tr><tr><td>Appointments verified*</td><td>13</td></tr><tr><td>April</td><td>4</td></tr><tr><td>May</td><td>4</td></tr><tr><td>June</td><td>5</td></tr><tr><td>Engagement rate*</td><td>3%</td></tr></table> Reorganization on reporting during mid-year. We will have year over year reporting going forward. Due/overdue or combination of the two will be clarified going forth.	June	674	Appointments scheduled*	44	April	9	May	15	June	20	Appointments verified*	13	April	4	May	4	June	5	Engagement rate*	3%	<table><tr><td>August</td><td>33</td></tr><tr><td>September</td><td>5</td></tr><tr><td>Appointments scheduled*</td><td>5</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>5</td></tr><tr><td>September</td><td>1</td></tr><tr><td>Appointments verified*</td><td>2</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>2</td></tr><tr><td>September</td><td>0</td></tr></table> Q4 7/1/2025-9/30/2025 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Enrollees (due)</td><td>52</td></tr><tr><td>Call attempts* Totals</td><td>152</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>129</td></tr></table>	August	33	September	5	Appointments scheduled*	5	July	0	August	5	September	1	Appointments verified*	2	July	0	August	2	September	0	Measure	Outcome	Enrollees (due)	52	Call attempts* Totals	152	July	0	August	129
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		<u>Successful contacts</u>: Coordinator engaged with Enrollee/Parent/Guardian <u>Voicemails</u>: Coordinator left a voicemail for the Enrollee after an unsuccessful contact <u>Appointments scheduled</u>: Coordinator assists with scheduling appointment(s) <u>Completed Appointments</u>: Coordinator contacts PCP to verify completion of scheduled appointment(s). Includes wellness day completed appointments. <u>Engagement rate</u>: Number of successful contacts divided by the number of call attempts	Measure	Outcome																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																												
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Total EPSDT-Eligible Enrollees 6 Months to 6 Years Old Receiving Preventive Lead Screening Services	Lead Screening	EPSDT Blood Lead Screening Telephonic Outreach and Appointment Scheduling Objective: Increase the number of Enrollees receiving necessary blood lead screenings Target Population: While MedStar Family Choice aims to engage families of young children to complete their recommended two blood lead screenings by the age of 2, outreach efforts are targeted at all EPSDT-eligible Enrollees due/overdue for one or both lead screens between the ages of 6 months to 6 years. Description: EPSDT Outreach Coordinators make calls to parents/guardians/Enrollees that are due and overdue for blood lead screening Actions:	Q1 10/1/2024-12/31/24 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Call attempts*</td><td>9,489</td></tr><tr><td>October</td><td>3,436</td></tr><tr><td>November</td><td>2,706</td></tr><tr><td>December</td><td>3,347</td></tr><tr><td>Successful contacts*</td><td>6,144</td></tr><tr><td>October</td><td>2,577</td></tr><tr><td>November</td><td>1,892</td></tr><tr><td>December</td><td>1,675</td></tr><tr><td>Engagement rate*</td><td>65%</td></tr></table> Q2: 1/1/25-3/31/25 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Call attempts</td><td>2,250</td></tr><tr><td>January</td><td>2,248</td></tr><tr><td>February</td><td>0</td></tr><tr><td>March</td><td>2</td></tr></table>			Measure	Outcome	Call attempts*	9,489	October	3,436	November	2,706	December	3,347	Successful contacts*	6,144	October	2,577	November	1,892	December	1,675	Engagement rate*	65%	Measure	Outcome	Call attempts	2,250	January	2,248	February	0	March	2	Q3 - 4/1/2025-6/30/25 *Overall Lead Screening completion for FY2025 FY2025 Q3 368-Blood Lead Tests performed 138 -Now Compliant with both lead screenings	Q4 7/1/2025-9/30/2025 <table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Enrollees (Overdue)</td><td>4</td></tr><tr><td>Call attempts* Totals</td><td>5</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>3</td></tr><tr><td>September</td><td>2</td></tr><tr><td>Appointments scheduled*</td><td>5</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>5</td></tr><tr><td>September</td><td>1</td></tr><tr><td>Appointments verified*</td><td>0</td></tr><tr><td>July</td><td>0</td></tr></table>	Measure	Outcome	Enrollees (Overdue)	4	Call attempts* Totals	5	July	0	August	3	September	2	Appointments scheduled*	5	July	0	August	5	September	1	Appointments verified*	0	July	0
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Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. & 2		Qtr. 3	Qtr. 4																																										
		Parents/Guardians/Enrollees are called and provided education on the importance of blood lead screenings and an EPSDT Coordinator assists with appointment scheduling with an Enrollee’s PCP or through our mobile lab vendor, Phlebotomy on Wheel (POW). • EPSDT Outreach Coordinators arrange transportation to/from appointments, as needed. • Coordinators then call parents/guardians/Enrollees to remind them of upcoming appointments at least 3 days prior. • EPSDT Outreach Coordinators call provider offices to confirm if the Enrollee completed the appointment as scheduled. • EPSDT Outreach Coordinators also share a list of appointments scheduled with POW. • POW will return the list indicating which appointments were kept and which were not. • EPSDT Outreach Coordinators contact Parents/Guardians/Enrollees to reschedule missed appointments. *Definitions: <u>Call attempts</u>: Number of times EPSDT Outreach Coordinator makes calls to Enrollees	<table><tr><td>Successful contacts</td><td>1,313</td></tr><tr><td>January</td><td>1,311</td></tr><tr><td>February</td><td>0</td></tr><tr><td>March</td><td>2</td></tr><tr><td>Engagement rate</td><td>58%</td></tr></table> *Overall Lead Screening completion for FY2025 Qtr 1 & 2: 261	Successful contacts	1,313	January	1,311	February	0	March	2	Engagement rate	58%			<table><tr><td>August</td><td>0</td></tr><tr><td>September</td><td>0</td></tr></table> Q4 7/1/2025-9/30/2025 <table><tr><th colspan="2"></th></tr><tr><th>Measure</th><th>Outcom</th></tr><tr><td>Enrollees (due)</td><td>18</td></tr><tr><td>Call attempts* Totals</td><td>28</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>18</td></tr><tr><td>September</td><td>11</td></tr><tr><td>Appointments scheduled*</td><td>1</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>0</td></tr><tr><td>September</td><td>1</td></tr><tr><td>Appointments verified*</td><td>7</td></tr><tr><td>July</td><td>0</td></tr><tr><td>August</td><td>7</td></tr></table>	August	0	September	0			Measure	Outcom	Enrollees (due)	18	Call attempts* Totals	28	July	0	August	18	September	11	Appointments scheduled*	1	July	0	August	0	September	1	Appointments verified*	7	July	0	August	7
Successful contacts	1,313																																															
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Appointments scheduled*	1																																															
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September	1																																															
Appointments verified*	7																																															
July	0																																															
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Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. & 2	Qtr. 3	Qtr. 4												
		<u>Successful contacts</u> : Number of times EPSDT Outreach Coordinator engaged with Enrollee <u>Engagement rate</u> : Number of successful contacts divided by number of call attempts			<table><tr><td></td><td>September</td><td>0</td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table>		September	0									
	September	0															
Total EPSDT-Eligible Enrollees 6 Months to 5 Years Old Receiving Preventive Lead Screening Services	Lead Screening	EPSDT Outreach by Mail – Blood Lead Screenings Objective: To encourage attendance at regular wellness visits where lead screenings would be provided Description: - Parents/guardians of Enrollees that are due and overdue for blood lead screenings are mailed letters to schedule blood lead screenings that have not yet been completed. - The letter also includes information about required immunization if needed, how to obtain transportation and scheduling assistance through MFC-DC Outreach Department.	Q1: 10/1/2024-12/31/2024 & Q2: 1/1/2025-3/31/2025 MFC-DC will start mailing letters out in the middle of Quarter 3.	Not Applicable Mail regarding Lead is included with WCV/Dental	Q4 7/1/2025-9/30/2025 Mail regarding Lead is included with WCV/Dental WCV/Dental/Immunization Mailed: 194 Letters												

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Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. & 2	Qtr. 3	Qtr. 4
Total EPSDT-Eligible Enrollees Receiving One of the EPSDT Initial Periodic Screening	WCV/Dental/Lead	Wellness Events Objective: The goal of Wellness Events is to form collaborative community partnerships with providers to increase access to healthcare services. As well as, to provide parents/guardians/Enrollees education about the importance of routine, preventative healthcare services. Description: During a wellness event MFC-DC partners with a community provider that will block off time on their schedule to exclusively service MFC-DC Enrollees. Enrollees who are due/overdue for services are invited to participate in Wellness Events based on the proximity of their home address to the event location. Actions: EPSDT Outreach Coordinators call parents/guardians/ Enrollees to provide education about the importance of needed services, schedule appointments for the day of the Wellness Event, and help with arranging transportation to/from appointments as needed.	Q1 10/1/2024-12/31/24 Provider: Elaine Ellis (WCV) Date: 10/9/24, 11/13/24, 12/11/24 Enrollees Targeted: 1-20 yrs Appointments Scheduled: 29 Enrollee Attended: 10 Adventure Dental (Dental) Date: 10/16/24, 11/20/24, 12/18/24 Enrollees Targeted: -20 yrs Appointments Scheduled: 59 Enrollee Attended: 39 Shining Stars Pediatric Dental (Dental) Date: 10/23/24, 11/27/24, 12/11/24, 12/18/24 Enrollees Targeted: -20 yrs Appointments Scheduled: 6 Enrollee Attended: 4 Q2: 1/1/25-3/31/2025 Shining Stars Pediatric Dental (Dental) Date: 1/8/25, 1/22/25, 2/26/25, 3/26/25 Enrollees Targeted: -20 yrs Appointments Scheduled: 6 Enrollee Attended: 3	Q3 4/1/2025-6/30/25 Provider: Elaine Ellis (WCV) Date: 5/14/25, 6/11/25 Enrollees Targeted: 1-20 yrs Appointments Scheduled: 5 Enrollee Attended: 5 Shining Stars Pediatric Dental (Dental) Date: 4/9/25, 4/23/25, 5/14/25, 5/28/25, 6/11/25, 6/25/25 Enrollees Targeted: -20 yrs Appointments Scheduled: 18 Enrollee Attended: 12 Provider: Confident Primary Care (WCV) Date: 5/14/25, 5/28/25 Enrollees Targeted: 1-20 yrs Appointments Scheduled: 12 Enrollee Attended: 7 Provider: Zion Family Care (WCV) Date: 5/22/25 Enrollees Targeted: 1-20 yrs Appointments Scheduled: 6 Enrollee Attended: 3 Provider: Unity Health Care (WCV)	Q4 7/1/2025-9/30/2025 Targeted Population for Dental 3-20 & WCV 2-20 July Confident Care 07/18/2025-2 Gerald Family Care 07/10/2025 -7 Shinning Star Dental 07/9/2025-1 Shinning Star Dental 07/23/2025-2 August • Elaine Ellis 8/13/2025 # 5 • Zion Family Practice 8/14/2025 #10, • Gerald Family Care 8/21/2025 - #6 • Confident Primary 8/6/2025# 10 • Shining Stars Pediatric Dentistry 8/13/202 6 completed • Shining Stars Pediatric Dentistry 8/27/2025 7 completed September • Elaine Ellis 9/10/2025-4

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		Reminder calls and text messages are placed the day before the wellness event. An EPSDT Outreach Coordinator is present at the provider's office during the Wellness Event to: - Document Enrollee attendance - Confirm and update Enrollee demographic information No-show is a major concern with assigned providers. EPSDT Outreach Coordinators reschedule service(s) for any Enrollee who is unable to attend on wellness days.	Adventure Dental (Dental) Date: 2/19/25, 3/12/25 Enrollees Targeted: -20 yrs Appointments Scheduled: 16 Enrollee Attended: 4 Provider: Elaine Ellis (WCV) Date: 3/12/5 Enrollees Targeted: 1-20 yrs Appointments Scheduled: 2 Enrollee Attended: 0 Provider: Confident Primary Care (WCV) Date: 3/19/25, 3/26/25 Enrollees Targeted: 1-20 yrs Appointments Scheduled: 18 Enrollee Attended: 9	Date: 6/25/25 Enrollees Targeted: 13-under 21 yrs Appointments Scheduled: 17 Enrollee Attended: 5 Going forward starting in Q4 Outreach Coordinator will obtain feedback from Enrollee while rescheduling on reason for "no show".	- Dental Days Shinning Star 9/10/2025-3 - MCP Collaborative 09/20/2025- 6 - Dental Days Shinning Star- 9/24/2025 4 - HSCN Back To school 09/27/2025 -5
Total EPSDT Eligible Enrollees Receiving At Least One Initial or Periodic Screening	WCV/Dental/Lead	New Enrollee Orientation & Enrollee Advisory Committee Objective: The New Enrollee Orientations are meetings to educate new Enrollees about MFC-DC benefits, programs, and resources.	Q1: 10/1/2024-12/31/2024 Enrollee Advisory Committee (Zoom) Bi-Monthly Date: 12/5/2024 Q2: 1/1/2025-3/31/2025 New Enrollee Orientation (Zoom) Quarterly	Q3: 4/1/2024-6/30/2024 Enrollee Advisory Committee (Zoom) Bi-Monthly Date: 4/24/2025, 5/29/2025, 6/26/2025 New Enrollee Orientation (Zoom) Quarterly	Q4 7/1/2025-9/30/2025 Enrollee Advisory Committee (Zoom) Date: October 23,2025-15 New Enrollee Orientation (Zoom)

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		Both the Enrollee Advisory Committee and New Enrollee Orientation gives the Enrollee a chance to meet with our clinicians, care management team, and other Enrollees. Description: MFC-DC organizes these meetings virtually/in-person via the Zoom platform to aid in avoiding potential barriers to accessing the meetings. Other approaches to reducing barriers to participation include: • The MFC-DC Chief Medical Officer provides a Welcome Message and introduction to Enrollees • Community Relation Representative and Outreach Coordinators collect Enrollee feedback regarding health plan operations and quality of care • EPSDT Enrollees are educated on the importance of their child being up to date with well child visits, immunizations, dental, and lead testing. Additionally, they are informed about EPSDT outreach three step programs, Beginning Steps (0-2 yrs), Healthy Leaps (3-	Date: 1/23/2025	Date: 4/10/2025 Future meetings will track how many EPSDT enrollees have attended	Date: 08/06/2025- 2 enrollees 08/14/2025, - 12 enrollees

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		11 yrs), and Healthy Bound (12-20 yrs). - Enrollee can give feedback in real time on MFC-DC Health Programs, Telehealth, Transportation, Urgent Care, Enrollee Services, PCP/PDP, Case Management, Behavioral Health, translation, Outreach, EPSDT, Maternal Health Translation Services are provided			
Total EPSDT Eligible Enrollees Receiving At Least One Initial or Periodic Screening	WCV/Dental/Lead	EPSDT Televox Calls for New Enrollees Objective: To prompt new Enrollees to call MFC-DC Outreach and/or Care Coordinators for services Description: Automated telephone calls are conducted for all new Enrollees with a welcome message and information. The welcome message includes information about preventive care and Enrollee resources (handbook, identification cards, appointment scheduling, etc.) for inquiries.	Q1: 10/1/2023-12/31/2024 Televox calls to new Enrollees: 686 Q2: 1/1/2025-1/31/2025 Televox calls to new Enrollees: 218	Q3: 4/1/2023-6/30/2024 Televox calls to new Enrollees: 1,975	Q4 7/1/2025-9/30/2025 July-68 August-70 September 72- Total calls 210

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		The EPSDT Outreach team follows up with new Enrollees, and/or Parent/Guardians to conduct a welcome call. These calls confirm their PCP, attempt to schedule appointments, and provide support including transportation services, etc.																																																																															
Less than 80% of EPSDT-Eligible Enrollees Received At Least One Well-Child Visit	WCV/Dental/Lead	EPSDT Care Text Message Objective: To educate and engage Enrollees who are due and overdue for EPSDT services through text messages Description: Messages will encourage completion of EPSDT preventive health services and include information on how to schedule necessary care. A (Yes) response implies how many Enrollees responded, and (No) how many Enrollees responded.	Q1: 10/1/2024-12/31/2024	Q2: 4/1/2025-6/30/2025	Q4 7/1/2025-9/30/2025																																																																												
			<table><tr><th>Message Type</th><th>Messages Sent/ Response</th></tr><tr><td>WCV/Lead (0-21 yrs.) Total</td><td>23,736</td></tr><tr><td>10/15/2024</td><td>8,491</td></tr><tr><td>Yes</td><td>95%</td></tr><tr><td>No</td><td>5%</td></tr><tr><td>Response Rate</td><td>2%</td></tr><tr><td>10/18/2024</td><td>5,220</td></tr><tr><td>Yes</td><td>96%</td></tr><tr><td>No</td><td>4%</td></tr><tr><td>Response Rate</td><td>0%</td></tr><tr><td>11/20/2024</td><td>8,524</td></tr><tr><td>Yes</td><td>97%</td></tr><tr><td>No</td><td>3%</td></tr><tr><td>Response Rate</td><td>2%</td></tr><tr><td>11/22/2024</td><td>436</td></tr><tr><td>Yes</td><td>100%</td></tr><tr><td>No</td><td>0%</td></tr><tr><td>Response Rate</td><td>1%</td></tr></table>	Message Type		Messages Sent/ Response	WCV/Lead (0-21 yrs.) Total	23,736	10/15/2024	8,491	Yes	95%	No	5%	Response Rate	2%	10/18/2024	5,220	Yes	96%	No	4%	Response Rate	0%	11/20/2024	8,524	Yes	97%	No	3%	Response Rate	2%	11/22/2024	436	Yes	100%	No	0%	Response Rate	1%	<table><tr><th>WCV/Lead (0-21 yrs.) Total</th><th></th></tr><tr><td>4/3/2025</td><td>1,360</td></tr><tr><td>Yes</td><td>13</td></tr><tr><td>No</td><td>2</td></tr><tr><td>4/23/2025</td><td>508</td></tr><tr><td>Yes</td><td>0%</td></tr><tr><td>No</td><td>144</td></tr><tr><td>4/23/2025</td><td>3,216</td></tr><tr><td>Yes</td><td>5</td></tr><tr><td>No</td><td>0</td></tr><tr><td>4/30/2025</td><td>369</td></tr><tr><td>Yes</td><td>0</td></tr><tr><td>No</td><td>0</td></tr><tr><td>4/30/2025</td><td>1,466</td></tr><tr><td>Yes</td><td>6</td></tr><tr><td>No</td><td>0</td></tr><tr><td>5/14/2025</td><td>3,208</td></tr><tr><td>Yes</td><td>2</td></tr><tr><td>No</td><td>0</td></tr><tr><td>5/22/2025</td><td>1,530</td></tr></table>	WCV/Lead (0-21 yrs.) Total		4/3/2025	1,360	Yes	13	No	2	4/23/2025	508	Yes	0%	No	144	4/23/2025	3,216	Yes	5	No	0	4/30/2025	369	Yes	0	No	0	4/30/2025	1,466	Yes	6	No	0	5/14/2025	3,208	Yes	2	No	0	5/22/2025	1,530
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			12/3/2024	1,065		Yes	4			
			Yes	100%		No	0			
			No	0%						
			Response Rate	1%						
			Dental (1-21 yrs) Total	8,347						
			10/3/2024	373						
			Yes	100%						
			No	0%						
			Response Rate	0%						
			10/9/2024 Adventure Dental	1,618						
			Yes	100%						
			No	0%						
			Response Rate	2%						
			10/11/2024 Shining Stars	582						
			Yes	100%						
			No	0%						
			Response Rate	1%						
			10/22/2024 Adventure Dental	1,618						
			Yes	100%						
			No	0%						
			Response Rate	1%						
			11/11/2024 Shining Stars	379						

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			Yes	100%		
			No	0%		
			Response Rate	1%		
			11/13/2024 Adventure Dental	1,616		
			Yes	100%		
			No	0%		
			Response Rate	1%		
			11/21/2024 Shining Stars	385		
			Yes	100%		
			No	0%		
			Response Rate	1%		
			12/3/2024 Adventure Dental	917		
			Yes	100%		
			No	0%		
			Response Rate	2%		

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			12/17/2024	859		
			Yes	100%		
			No	0%		
			Response Rate	0%		
			Q2: 1/1/2025-3/31/2025			
			WCV/Lead (0-21 yrs.) Total	28,789		
			1/7/2025	8,536		
			Yes	100%		
			No	0%		
			Response Rate	2%		
			2/3/2025	1,827		
			Yes	100%		
			No	0%		
			Response Rate	1%		
			2/24/2025	8,559		
			Yes	100%		
			No	0%		
			Response Rate	1%		
			2/27/2025	642		
			Yes	100%		

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			No Response Rate 3/19/2025 Yes No Response Rate 3/19/2025 Yes No Response Rate	0% 1% 8,583 98% 2% 1% 642 100% 0% 1%																										
			<table><tr><th>Message Type</th><th>Messages Sent</th></tr><tr><td>Dental (1-21 yrs) Total</td><td>5,357</td></tr><tr><td>1/24/2025 Shining Stars</td><td>1,447</td></tr><tr><td>Yes</td><td>100%</td></tr><tr><td>No</td><td>0%</td></tr><tr><td>Response Rate</td><td>0%</td></tr><tr><td>1/31/2025 Adventure Dental</td><td>374</td></tr><tr><td>Yes</td><td>100%</td></tr><tr><td>No</td><td>0%</td></tr><tr><td>Response Rate</td><td>1%</td></tr><tr><td>2/12/2025 Adventure Dental</td><td>1,613</td></tr><tr><td>Yes</td><td>100%</td></tr></table>	Message Type	Messages Sent	Dental (1-21 yrs) Total	5,357	1/24/2025 Shining Stars	1,447	Yes	100%	No	0%	Response Rate	0%	1/31/2025 Adventure Dental	374	Yes	100%	No	0%	Response Rate	1%	2/12/2025 Adventure Dental	1,613	Yes	100%			
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1/31/2025 Adventure Dental	374																													
Yes	100%																													
No	0%																													
Response Rate	1%																													
2/12/2025 Adventure Dental	1,613																													
Yes	100%																													

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			No 0% Response Rate 1% 2/18/2025 Adventure Dental 1,433 Yes 100% No 0% Response Rate 1% 3/3/2025 167 Yes No response No No response Response Rate 0% 3/3/2025 Adventure Dental 323 Yes 100% No 0% Response Rate 2%				
			*Populations were being targeted for wellness events				
Total EPSDT Eligible Enrollees Receiving At least One Initial or Periodic WCV Screening	WCV/Dental/Lead Compliance	Wellness Center Objective: To have program and services that address gaps of care and provide support and resources to EPSDT Enrollees.	Q1 - 10/1/2024-12/31/24 Q2: 1/1/2025-3/31/25 The opening of Wellness Center occurred on 1/14/2025.			Q3 - 4/1/2025-6/30/25 The Wellness Center offers health services to enrollees who reside in Ward 7 & 8. Lead screenings can be completed with provider (Lab Corp).	Q4 - 7/1/2025-9/30/25 Enrollees ages 15-17 years are offered a Culinary Class. This class provides learning to prepare healthy/tasty foods.

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		Target Population: Enrollees residing in Wards 7 and 8 (0-21 years of age) Description: The center will have an Outreach Coordinator who will help parent/guardian or Enrollee with scheduling appointments with providers. As well as provide education on healthy lifestyles, development and illness prevention. Wards 7 and 8 are the intended target population for the center. These wards have the lower rates of attendance for well-child visits.		Enrollees ages 15-17 years are offered a Culinary Class. This class provides learning to prepare healthy/tasty foods.	- July 1-July 31- 6 participants - Sept 18th- October 23rd- 2 participants																						
Total EPSDT Eligible Enrollees Receiving At least One Initial or Periodic WCV Screening	WCV Compliance	School Based Health Center (SBHC) Partnership Objective: To increase WCV compliance. Target population: High school Enrollees who are due and overdue for WCV. Description: High school Enrollees who are due and overdue for WCV, MFC-DC will work with SBHC’s to increase utilization of preventive health care services. A large emphasis during summer will be focused on EPSDT population getting WCV compliant. Action:	Q1: 10/1/2024-12/31/2024 & Q2: 1/1/2025-3/31/2025 Update on when the list will be shared. DHCF will provide a list on 4/18/2025. MFC-DC will contact health centers and set up a wellness day.	Q3 - 4/1/2024-6/30/24	Q4 7/1/2025-9/30/2025																						
				<table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Call attempts* Totals</td><td></td></tr><tr><td># of Enrollees</td><td>84</td></tr><tr><td># of Enrollees Who Are Assigned to SBHC’s</td><td>40</td></tr></table>	Measure	Outcome	Call attempts* Totals		# of Enrollees	84	# of Enrollees Who Are Assigned to SBHC’s	40	<table><tr><th>Measure</th><th>Outcome</th></tr><tr><td>Call attempts* Totals</td><td>1447</td></tr><tr><td>July</td><td>497</td></tr><tr><td>August</td><td>336</td></tr><tr><td>September</td><td>614</td></tr><tr><td># of Enrollees</td><td>447</td></tr><tr><td># of Enrollees Who Are Assigned to SBHC’s</td><td>447</td></tr></table>	Measure	Outcome	Call attempts* Totals	1447	July	497	August	336	September	614	# of Enrollees	447	# of Enrollees Who Are Assigned to SBHC’s	447
				Measure	Outcome																						
				Call attempts* Totals																							
				# of Enrollees	84																						
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# of Enrollees	447																										
# of Enrollees Who Are Assigned to SBHC’s	447																										
Enrollees assigned to (7) SBHC’s are being contacted by EPSDT Coordinators																											
<u>Location of SBHC’s</u> Anacostia High School Ballou High School Cardozo High School																											

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		Having staff visit the schools to share relevant information with staff and students and organize events. The goal of this partnership is to share data with SBHC about Enrollees assigned to MFC who attend this school who are due or overdue for healthcare screenings. - Update demographics - Overcome barriers (transportation and scheduled appointment time with PCP)		Coolidge High School Dunbar High School Roosevelt High School Woodson High School Coordinators are actively engaging SBHC to verify student demographic and contact details, confirming hours of operation and summer availability. Woodson SBHC list has been completed during this quarter.	
Less than 80% of EPSDT-Eligible Enrollees Received At Least One Well-Child Visit	WCV/Dental/Lead	Collecting EPSDT Supplemental Data Objective: To improve accuracy of EPSDT reporting for WCV and to support data reporting around Enrollee compliance Description: EPSDT Outreach Coordinators and Quality Improvement Specialists collect medical records and supplemental data from providers to close gaps in care for EPSDT services through Electronic Medical Record (EMR) system access agreements with provider organizations or in-person at provider offices. Supplemental Data allows	Q1: 10/1/2024-12/31/2024 Electronic Medical Records Retrieved (remote/provider office): 13 Q2: 1/1/2025-3/31/2025 Electronic Medical Records Retrieved (remote/provider office): 17	Q3 - 4/1/2024-6/30/24 Electronic Medical Records Retrieved (remote/provider office): 18 Project Plan has been initiated to increase the amount of supplemental data ingested into MFC from multiple provider EHR system. This will improve ability to target non-compliant Enrollees for outreach and improves gaps in care reports for providers.	Q4 7/1/2025-9/30/2025 Q4 reporting we submitted 3805 for supplemental data.

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		for more precise and complete reporting of Healthcare Effectiveness Data. Quality Improvement Specialists review records to confirm if WCVs, preventive dental care appointments, and/or lead screenings were completed and accurately recorded. Currently MedStar Family Choice DC has access to records at Unity Health Care, Mary's Center, Howard, Community of Hope and Children's National.			
Total EPSDT Eligible Enrollees Receiving At Least One Initial or Periodic Screenings	WCV/Dental/Lead	MFC-DC Staff EPSDT Training Objective: To educate EPSDT and Outreach Coordinators on Well-Child Visits, recommended dental care, lead screening, and Immunization Charts Description: In an effort to increase the compliance rate for (WCV, Dental, Lead) the Outreach team has been redesigned to ensure the EPSDT Team is adhering to the DC Medicaid HealthCheck Periodicity Schedule (WCV, Lead, Dental).	Q1: 10/1/2024-12/31/2024 Outreach productivity is reviewed and discussed with coordinators bi-weekly. Challenges and barriers are discussed during meeting. In addition, discussion includes HealthCheck Periodicity Schedule and HEDIS measurements. Attended Immunize DC Webinars 12/3/2024 Q2: 1/1/2025-3/31/2025 1/22 & 27 The quality department held a refresher HEDIS measures training for all staff that speak with Enrollees. This training	No Training in Q3	Q4: 7/1/2025-9/30/2025 The quality department held a refresher HEDIS measures training for all staff that speak with Enrollees. Training August 25th to go over Guiding Care documentation, EPSDT reporting metrics. Training for measures dental, lead, and wcv held during this training.

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			included all measures related to EPSDT services. The purpose was to review the measure, the applicable ages, purpose of the measure so outreach staff understand how these services relate to improved outcomes for our Enrollees. Outreach productivity is reviewed and discussed with coordinators bi-weekly. Challenges and barriers are discussed during meeting. In addition, discussion includes HealthCheck Periodicity Schedule and HEDIS measurements Attended Immunize DC Webinars 1/16/2025		

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MCO: Wellpoint

FY ‘24 Participant Ratio: 55%

FY ‘25 Goal Participant Ratio: 80

Quarterly Goals: Q1: 44% Q2: 44% Q3: 47% Q4: 51%

Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. 1 & 2	Qtr. 3	Qtr. 4
	WCV/Lead/ Dental	Targeted Outreach Objective: - To educate enrollees on the importance of preventative care and EPSDT. - Inform enrollees that they are due or overdue preventative services including WCV, Dental and/or Lead. - Schedule children for WCV, Dental and/or Lead screenings as well as assist with scheduling for transportation services to appointments. - Increase compliance rate for WCV, Dental, and Lead Target Population: - Children who are due and overdue for WCV, Dental and/or Lead screenings - Enrollees’ eligible early intervention services and participate in the weekly IFSP meetings. Activities: - Outreach which includes Phone Calls, Mailers, and Face to Face Visits - Phone calls: Assist enrollees with scheduling appointments with PCP and assist with transportation to appointment. - Educate families and enrollees on EPSDT, and healthy reward benefits for completing health activity.	<u>FY25 Qtr. 1 & 2</u> Birthday Mailers Sent: 5,598 Overdue Mailers Sent: 2,555 <u>FY25 Q2 -Text Campaign</u> Due Reminder: 389 Overdue Reminder: 168 <u>FY25 Qtr. 1 & 2</u> Calls Targeted: 835 Calls Made: 835 WCV Scheduled: 247(29%) <u>FY25 Qtr. 1 & 2</u> Face2Face Targeted: 980 Contact Made: 477 WCV Scheduled: 61	<u>Mailers:</u> Targeted Birthday: 5,541 Birthday Mailers Sent: 3,379 Target Overdue: 2,459 Overdue Mailers Sent: 1,747 <u>Text Campaign:</u> Due Reminder: 442 Overdue Reminder: 153 <u>Telephonic:</u> Targeted Calls: 3,626 Calls Made: 971 <u>Face-to-Face:</u> Face2Face Targeted: 187 Contact Made: 187 <u>Early Intervention (IFSP) Meeting:</u> Contact Made: 115 Families/Caregivers	<u>Mailers:</u> Targeted Birthday: 6,089 Birthday Mailers Sent: 3,748 Target Overdue: 3,809 Overdue Mailers Sent: 2,202 <u>Text Campaign:</u> Due Reminders: 156 Overdue Reminders: 395 <u>Telephonic:</u> Targeted Calls: 6,551 Calls Made: 1,948 <u>Face-to-Face:</u> Face2Face Targeted: 869 Contact Made: 869 <u>Early Intervention (IFSP) Meeting:</u> Contact Made: 79 Families/Caregivers Telephonic and Face to Face Outreach Overall Scheduled Outcomes:

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		<u>Updates based on feedback:</u> Weekly Individualized Family Service Plan (IFSP) meetings help improve the participant ratio by reminding families to schedule preventative care services. During these meetings, we connect families with resources for transportation and translation, ensuring easy access to necessary healthcare, thus boosting participation rates. Enrollees eligible for early intervention services, aged 0-3 years, are a key focus for our EPSDT program as they require multiple preventive care services at this age range. It's important to remind families of these health milestones to maintain compliance. Weekly Individualized Family Service Plan (IFSP) meetings are attended by the enrollee's family or caregiver. Enrollee Advisory Committee (EAC): Amerigroup hosts a quarterly meeting to provide educational information regarding enrollees' health plan benefits, EPSDT preventative services, case management and community resources. The EAC is comprised of new and established enrollees. Case managers are available during this time to provide support with community sources, appointment scheduling and other social services. Maternal Wellness Events (Enrollee Baby shower): Every third Wednesday of the month, Amerigroup hosts a Baby Shower in our wellness center. This event connects new and expectant mothers with essential education on Safe Sleep and EPSDT preventative services. Case managers are available on-site to assist families in coordinating services for both mom and baby. This is also an excellent opportunity to increase participant ratio, as we can help with schedule appointments for newborns and other siblings. <u>Q3. Updates based on feedback:</u> Targeted Outreach: Our outreach targets are established by identifying enrollees based on their birthdays for upcoming services. These individuals receive reminders through mailers and	FY25 Qtr. 1 - Enrollee Advisory Committee: Date: 12/3/2024 Total Targeted: 40 Outcome: 4 enrollees 1 Avesis – Provided enrollee education on dental benefits, accessing PCP (10%) FY25 Q1. & Q2 Early Intervention (IFSP) Meeting: Contact made: 218 families/caregivers Maternal Wellness Wednesdays: Date: 12/11/2024 Total targeted: 25 Outcome: 7 enrollees (28%) 2 CBE/CBO Food Jonezi - provided healthy food demo Mamatoto Village Date: 2.19.2025 Total Outreached: 20	Telephonic and Face to Face Outreach Overall Scheduled Outcomes: Well Care Visits Scheduled: - 130 scheduled Lead Screenings scheduled: - 23 scheduled Dental Screenings Scheduled: - 16 scheduled Outcome Measures in Qtr. 3: - 2,812 enrollees completed a Well Care Visit - 1,577 enrollees received a preventative dental service - 263 enrollees completed a blood lead screening	Well Care Visits Scheduled: - 429 scheduled Lead Screenings scheduled: - 83 scheduled Dental Screenings Scheduled: - 48 scheduled Outcome measures in Qtr. 4 following outreach attempts: - 260 enrollees who were outreached completed a Well Care Visit - 7 enrollees who were outreach received a Preventative Dental service - 12 enrollees who were outreached completed a Blood Lead Screening

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		telephonic outreach. For enrollees overdue by 45 days, we employ targeted mail and telephonic outreach. If three telephonic attempts are unsuccessful, we proceed with face-to-face engagement to ensure the necessary services are received. <u>Plaintiff's Comments:</u> Birthday mailers are sent to enrollees with birthdays in the next 60 days. Overdue mailers target enrollees who are 45 days overdue for EPSDT services based on their birthday. Enrollees who receive a birthday mailer will not receive an overdue mailer in the same quarter, as the mailing schedules are structured to prevent overlap. <u>Enrollee Advisory Committee:</u> Currently, there are no plans to track well-child visits tied to the Enrollee Advisory Committee meetings due to low turnout, and the inability to guarantee how many EPSDT Eligible Parents/Guardians will be able to attend. Future enhancements to the EAC may provide better tracking capabilities, which could be updated to include this level of detail.	Outcome: 7 enrollees (35%) 1 CBE: Food Jonezi provided healthy food demo Date: 3.19.2025 Total Outreached: 20 Outcome: 8 enrollees (40%) 1 CBE: Food Jonezi provided healthy food demo		
	WCV/Lead/Dental/Immunization	Community Wellness Event: EPSDT Screening Objective: - Increase compliance of well-child visits and immunization among children who are due or overdue for preventative EPSDT services. - Establish continued partnerships with community providers, and other community-based organizations. Target Population:	FY25 Qtr. 1 & 2 Provider: Unity Health Care (Brentwood) Date: 10/26/2024 Scheduled: 22 Screened: 8 (36%) National Children's Dental Health Month	<u>Screening/Direct Services:</u> Provider: Adventure Dental Date: 5/14/2025 Scheduled: 7 Screened: 5 Provider: Adventure Dental	Bright Beginnings Screening Provider: C3 Cares Service: WCV and Lead Screening Date: 9/3/2025 (Postponed) *Low registration United Planning Organization (UPO) Provider: C3 Cares Service: WCV and Lead Screening

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		- Children between 0-20 who are due or overdue for WCV, Immunizations, Lead screening and/or Dental screenings. Activity: - Targeted outreach calls to assist enrollees with scheduling appointments for well-child visits, lead screening, immunization and/or dental screenings. - Assisted enrollees with transportation to appointments. - AMG set up table to engage enrollees and community members at the screening event. - Educated enrollees and community members about Amerigroup benefits including transportation, healthy rewards, and more. - Provided insurance renewal information, to Medicaid recipients. <u>Updates based on feedback: (qt1.)</u> Wellness events are conducted to provide an opportunity for enrollees who are Due or Overdue for preventative services to receive 1-3 of the following services: WCV, Lead Screening and/or oral health exams based on the event focus. EPSDT health screening events target overdue children by first conducting an internal data review to pinpoint wards and zip codes with high rates of noncompliance. We then connect with clinical providers who practice in these areas, as they are already serving the children most in need. By collaborating with these local providers, we	Provider: Adventure Dental Date: 2.19.2025 Screened: 2 Scheduled: N/A enrollees were not scheduled for this invite. <u>Educational Services:</u> Deanwood Recreation Center Date: 2.15.2025 Engaged: 40 Families AMG provided dental kits and encouraged enrollees and their families to complete dental screenings and cleanings. Wider Circle – Diaper Days Date: 2.13.2025 Engaged: 27 Howard Center of Excellence – Diaper Days Date: 2.13.2025	Date: 6/18/2025 Scheduled: 11 Screened: 5 In Qtr. 3 Wellpoint collaborated with Adventure Dental to host a dental screening day at their Brentwood location. Enrollees were able to schedule an appointment and receive a preventative dental service on these dates. Screened – refers to the number of enrollees who were provided a preventative dental service. <u>Educational Services:</u> Horton’s Kids Hub Date: 5/3/2025 Engaged: 60 families Scheduled: 1 enrollee was scheduled for our dental wellness day at Adventure dental on May 14th. Wellpoint provided families with educational	Date: 9/24/2025 (postponed) *Low registration Back to School Screening Provider: Howard University Date: 9/27/2025 Scheduled (WCV): 3 Screened: 0 Provider: Unity Health Care (Brentwood) Date: 9/20/2025 Scheduled: 12 Screened (WCV): 4 Screened (Dental): 3 <u>Education/Tabling Event:</u> Back to School/ Community Day POWAB Date: 8/23/2025 Scheduled for WCV: 0 DCPS Back to School Date: 9/13/2025 Scheduled for WCV: 0

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		organize targeted health screening events to ensure children receive the necessary services and reduce overdue rates. In addition to direct EPSDT health services, we participate in community events to provide enrollees with information on EPSDT and health plan benefits. During these events, we can connect enrollees with outreach specialists who can assist with scheduling appointments and arranging transportation to services, ensuring comprehensive access to preventive care. <u>Updates based on feedback: Consideration of Value (qtr. 3)</u> At year-end, Wellpoint will review its workplan to assess the success of collaborative activities and identify partnerships that should be discontinued. Despite our past collaboration with Unity Health Care not achieving significant success, we find it valuable to continue due to Unity's extensive engagement with our enrollees—about 40% of our EPSDT-eligible enrollees have a primary care provider there. Moving forward, we aim to expand our health initiatives by incorporating activities such as offering adult well visits, potentially allowing families to be screened simultaneously. <u>Plaintiff Comments:</u> A high rate of non-compliance pertains to enrollees who are overdue for EPSDT services. Our goal is to target all overdue enrollees, particularly those living in zip codes identified with significant non-compliance rates. By focusing on these areas, we aim to enhance overall compliance and promote better health outcomes for our enrollees.	Engaged: 30 Amerigroup connected with enrollees to emphasize the importance of well-child visits during the first and second 15 months, lead screening, and the incentives associated with these activities. <u>Update:</u> Provider: Whitman Walker WCV Date: Tentative March 15th Scheduled: N/A Screened: N/A Event postponed by provider until Monday, April 14th	fliers related to Well-care visits, immunizations, dental and lead screenings. We offered opportunities to schedule appointments for preventative health services.	

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		A high rate of non-compliance refers to enrollees who are overdue for EPSDT services. Our goal is to specifically target all enrollees who are overdue, focusing on those residing within zip codes that have been identified as having high rates of non-compliance (overdue) rates. By concentrating on these areas, we aim to improve overall compliance and ensure better health outcomes for our enrollees.			
		Pediatric Workgroup The pediatric workgroup consists of the following members for cross-sectional collaboration to achieve 80% for EPSDT compliance. - EPSDT Program Manager, Whole Health Director, Quality Management Director, Chief Medical Officer, Behavioral Health Manager, Early Intervention Case Managers, and Provider Network Management Director. Objective: - Identify data sources- Internal sources: Claims and Gaps in Care reports. External sources: MCO Panel update (FQHC), DHCF Immunization Data - Analyze data to identify performance and trends. - Identify barriers – to care, data collection, and data exchange. - Design and develop pilot interventions and collaterals to increase participant ratio in an addition to pediatric HEDIS measures Target Population: - EPSDT eligible enrollees between 0-20 years old. Activity:	Date: 10/9/2024 Cedar Hill Urgent Care: Our EPSDT workgroup met with Cedar Hill Urgent Care to discuss collaborative efforts on School Physicals and Vaccines opportunities. Outcome: Connected Cedar Hill team with provider network team to complete contracting for well child visits. Upcoming: AMG will be connecting with Cedar Hill at the beginning of the year to discuss scheduling wellness day events. Q2. Update:	Partners in Education: This quarter, our Partners-in-Education initiative achieved its goal of adding two additional schools to our collaborative efforts: # of schools identified: 2 1 DCPS high school 1 elementary public charter school Wellpoint connected with each school to discuss opportunities for in-school preventive health screening events. Additionally, through the Partners in Education	# of schools identified: 1 1 Charter School Friendship Charter Schools Preventative screening events scheduled for (PIE) school: 1 Preventative screening events completed for (PIE) school: 1

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		- Develop interventions and share best practices. - Review EPSDT compliance rates per qtr. and annually - Determine metric priorities for the health plan through on gaps in care and claim reports. Develop interventions for underperforming metrics ex. Health screening events, and education on importance of EPSDT preventative services. - Review MCO contract as well as technical proposal for all EPSDT requirements. <u>Q1. Update on based on feedback:</u> The goal of the collaborative partnership is to increase noncompliance rate of WCV for enrollees who have been out of care for 1 yr and/or live East of the River. Cedar Hill UC currently provides school health physicals and vaccines as part of their services. <u>Q3. Updates based on feedback:</u> Cedar Hill is equipped to provide comprehensive Well-Child Visits (WCVs) and immunizations to enrollees. However, as an urgent care clinic, Cedar Hill does not facilitate continuity of care for enrollees. The appointments are designed to offer families prompt access to services, such as immunizations, for those requiring immediate care. For continuous care and management needs, enrollees are encouraged to establish a relationship with a primary care provider.	<i>Partners in Education Initiative:</i> In collaboration with our marketing team, we have developed a partner in education initiative. This initiative is intended on improving the participant ratio by offering preventative health screenings to schools, host quarterly tabling events to provide education on health plan benefits and have linked recourses on school webpage (ex: link to SDOH community resource link, Wellpoint events, links to enrollee welcome guide and more)With this initiative we hope to see an increase in school health collaborations and develop partnerships outside of school-based health centers.	initiative, Wellpoint was able to host a school health screening event at Charles Hart Middle School and schedule an additional event for qtr. 4. The outcomes of this event are detailed in the School Health Partnerships section of this workplan. Preventative screening events scheduled for (PIE) school: 2 Preventative screening events completed for (PIE) school: 1	

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			# of schools identified: 5 JO Wilson, Cardozo, Hart Middle, Ballou HS, KIPP College Prep. Goal for Q3: Increase partnership by 2 schools (1 HS and 1 MS) These schools were identified through review of our internal noncompliant enrollees' report. For this initiative data is stratified by enrollee, age, last DOS, zip code and Ward. We continue to see find high trends of WCV noncompliance for school aged enrollees in Wards 5, 7 & 8 which helped in identifying schools such as Hart MS, Ballou HS, and KIPP College Prep.		

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		School Health/School Based Health Center (SBHC) Partnership Objective: - Increase of compliance of WCV, Immunization, and Dental screening among middle and high school aged children Target Population: - Middle & High school aged enrollees who are non-compliant for WCV, Immunizations or Dental screenings. - Enrollees assigned to one of the seven school-based health centers. As we await the school health list from DHCF, our EPSDT program proactively identifies the target population for any school health collaboration through an internal data review. We focus on two key metrics: noncompliant school-aged enrollees and specific wards or zip codes. This data helps us explore opportunities with schools in these areas, offer schools opportunities for preventative health screenings. Additionally, we are developing a collaborative process with the SBHCs at Woodson and Cardozo High Schools (Operated by Unity Health Care). The SBHCs will manage the cross-checking of enrollee details to determine their assigned facilities, while we focus on conducting outreach. Our goal is to schedule enrollees who are due or overdue for preventative health services at the SBHC to increase compliance rates as well as utilization of SBHC resources. Activity: - AMG will work to register students for the SBHC and assist with scheduling appointments for WCV and Vaccinations.	DCPS: Cardozo High School PTO Date: 10/30/2024 Engaged: 10 Families Amerigroup presented educational information on health plan benefits and EPSDT preventative health services. The presentation also highlighted how our program can connect enrollees with transportation, translation, and scheduling support. Roosevelt High School Winter PTO/A Date: 12/17/2024 Engaged: 30 Families. During this PTA meeting, Amerigroup provided Hats, Gloves, educational materials EPSDT preventative health services. No preventative health screenings were conducted at this time.	<u>Screening/Direct Services:</u> Kelly Middle School: Provider: C3 Cares Date: 4/10/2025 Scheduled: 6 Screened (WCV): 4 Columbia Heights Education Campus (CHEC) Provider: C3 Cares Date: 5//2025 Scheduled: 5 Screened: 1 Charles Hart Middle School Provider: C3 Cares Date: 6/4/2025 Scheduled: 20 Screened (WCV): 14 <u>Upcoming events:</u> Charles Hart Middle School Provider: C3 Cares Date: 8/6/2025 Scheduled: 14 Screened: TBD <u>Update based on feedback:</u>	<u>Screening/Direct Services:</u> Charles Hart Middle School Provider: C3 Cares Date: 8/6/2025 Scheduled:14 Screened (WCV): 10 <u>Education/Tabling Events:</u> DCPS Healthy Hub: Outreach event for students and families to access resources to health services. Immunizations, Dental, and Vision screenings were provided at some of the health hubs. Students were seen on a first come, first serve basis and no one was scheduled prior to event. These events averaged about ~15-20 students/families. Hart Middle School Date: 7/7/2025 Cardozo Education Campus Date: 7/9/2025 Hardy Middle School Date: 7/18/2025 Kramer Middle School Date: 7/25/2025

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October 1, 2024 to September 30, 2025

Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. 1 & 2	Qtr. 3	Qtr. 4
		- Educate enrollees and their families on the importance of preventative health services. - Collaborate with SBHC on immunization events to ensure that enrollees are compliant and enrolled in school.	Charles Hart Middle School Winter Extravaganza Date: 12/19/2024 Engaged: 100 Families During this event, Amerigroup provided Hats, Gloves, educational materials EPSDT preventative health services. No preventative health screenings were conducted at this time. Charles Hart Middle School Healthy Heart Month forum Date: 2.20.2025 Scheduled: No scheduling was conducted for this event. Screened: 75 Students Amerigroup organized nurses to conduct health screenings providing them with their blood pressure, blood sugar, and BMI statistics. Additionally,	Wellpoint will assess the value of these activities by evaluating the screening outcomes at each hosted event, as well as the frequency and quality of events facilitated through partnerships and engagement with schools. DCPS and charter school partnerships are particularly valuable as they enable us to reach children and families in their own environments. Given the substantial effort required to engage at these school events, Wellpoint's decision to continue these activities will depend on the measurable impact on community health outcomes and the strength and sustainability of our partnerships with schools.	Jefferson Middle School Date: 7/31/2025 Ida B. Wells Middle School Date: 8/7/2025 DPR End of Summer Teen Festival – Dunbar High School Date: 8/1/2025 Engaged: ~60 teens/families Scheduled for WCV Appt: 0 Back to School Night: Educare Child Care Center Date: 9/8/2025 & 9/9/2025 Scheduled for WCV Appt: 0 Back to School Bash 2025 DCPL – Bellevue Library w/ Community of Hope Date: 8/7/2025 Outreach event, Backpack and other school supply giveaways for families.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance
MCO EPSDT Work Plan
October 1, 2024 to September 30, 2025

Non-Compliant Element	Areas of Focus	Action Item(s) to Eliminate Barriers and Steps for Implementation	Qtr. 1 & 2	Qtr. 3	Qtr. 4
			participants gained valuable insights into prevention techniques for improving cardiovascular health. No EPSDT preventative health services were provided. <i>Update:</i> KIPP, Webb Campus Provider: C3 Cares Date: 3.11.2025 Scheduled: 6 Screened: 1		

Q35. Please provide the average length of time, in FY 2025 and FY2026, to date, for each MCO and FFS to complete:

- a. non-urgent prior authorizations.**
- b. Urgent prior authorizations; and**
- c. Long-term care prior authorizations.**

Response:

a. Non-urgent prior authorizations.

The following reflects time in business days.

FY 2025				
AmeriHealth	HSCSN	MedStar	Wellpoint	FFS
0.64	5	6.88	1.79	1.33

FY 2026				
AmeriHealth	HSCSN	MedStar	Wellpoint	FFS
0.27	3	1.73	2.16	1.71

b. Urgent prior authorizations

The following reflects time in business days.

FY 2025				
AmeriHealth	HSCSN	MedStar	Wellpoint	FFS
26.40	62	53	11.61	30

FY 2026				
AmeriHealth	HSCSN	MedStar	Wellpoint	FFS
7.71	11	24	57.25	20

c. Long-term care prior authorizations.

Although long-term care services are excluded from the managed care contracts administered by AmeriHealth, HSCSN, MedStar and Wellpoint, similar services are administered by the MCPs. The following lists the average length of time expended to complete prior authorizations for similar services.

The following reflects time in business days.

FY 2025				
AmeriHealth	HSCSN	MedStar	Wellpoint	FFS
3.65	15	6	1.43	6

FY2026				
AmeriHealth	HSCSN	MedStar	Wellpoint	FFS
2.62	6	1	0.75	3

* Please note that Wellpoint's FY26 data above does not include dental service prior authorization data, which is still pending final internal aggregation.

Q36. Please describe changes to any of the MCO and FFS patient portals completed in FY 2025 and FY 2026, to date, and planned changes for the remainder of FY 2026.

Response:

DHCF does not operate a patient portal for FFS beneficiaries.

AmeriHealth:

There were no material changes to the AmeriHealth Caritas DC portal in FY 2025. In FY 2026, AmeriHealth has indicated that it will improve the registration/sign-up process for enrollees who don't have their Medicaid and/or AmeriHealth ID number. AmeriHealth also plans to add a short new enrollee welcome survey that will allow all new enrollees to share any immediate transition of care, upcoming procedures or treatments, health concerns, or related needs that they may have.

HSCSN:

FY25

HSCSN enriched their shareable educational care programs, on demand articles and relevant links to include all relevant chronic diseases, pediatric and young adult content. Additionally, the patient portal grew with new programming, educational material specific to conditions, and information in Spanish. HSCSN also built out quick shareable links to all web-based plan materials.

FY26

For the coming year, HSCSN's Case Managers will have new technology solutions including integration with the Nurse Triage Line.

MedStar:

There have been no changes made to the MedStar Family Choice DC Enrollee Portal in FY2025 and FY2026 to date. There are also no planned changes for the remainder of FY2026.

Wellpoint:

Website

- June 2025: The enrollee website portal went through branding changes beginning in May with a banner sharing that Amerigroup DC would be becoming Wellpoint DC. The portal transitioned from Amerigroup branding to Wellpoint DC in June in preparation. In July all branding was complete. Contact information and updates related to the brand change were provided.

- December 2025: Alliance and Immigrant Children's Program (ICP) Enrollees: On October 1, 2025, you will no longer have Wellpoint DC or any managed care plan for your coverage. If you still have coverage under the Alliance program, Department of Healthcare Finance (DHCF) will act as your managed care plan. To make sure that you don't miss any information, look for mail

from DHCF and log into your account at District Direct for notices. You can also find out more at Health Care Alliance Program Changes (2025).

- December 2025: The DC Medicaid program is changing for adults on January 1, 2026. To make sure that you don't miss any important information, look for mail from DHCF and log in to your account at District Direct for notices. You can also find out more at <https://dhcf.dc.gov/medicaid-program-changes>.

- December 2025: Updates made to include information on data breach as follows: "Important member notice: Learn about a security incident at Conduent, a Wellpoint DC service provider."

Sydney Health App

- October 2024: Enrollees will see a message on the pharmacy landing page stating if they have a CaredonRx pharmacy prescription to fill.

- March 2025: All eligible Medicaid BioPlus Specialty enrollees will have the digital BioPlus experience where a enrollee can reschedule their prescription and track their shipment.

- May 2025: Enrollees will be able to utilize chatbot in Spanish when digital profile has language selected.

- June 2025: DC Medicaid market was rebranded to the Wellpoint DC brand. A message was displayed for 4 to 6 weeks before the brand change is effective so they will know that it is coming.

- September 2025: Enabled Modernized Security through the OKTA Security efforts.

- December 2025: Family Link - The head of household (HOH) with more than one family member on a Medicaid plan must manage multiple online accounts; one for each family member. Five family members equals five online accounts managed by the head of household. We will make it more user friendly for the HOH to access their minor account(s) by login through their own account.

- December 2025: Introduced a new dashboard landing page for DC Medicaid enrollees on secure Medicaid Web Portal and SH App.

37. Please provide on the following for the FY 2025 Budget Support Act Title V Subtitles C, D, and E, Medicaid Inpatient and Outpatient Fund and Directed Payments:

Response:

a. The status of the submission to Centers for Medicare and Medicaid Services and application details both for FY2025 and FY 2026;

The FY2025 State Directed Payment (SDP) and Tax Waiver have both been approved by the Centers for Medicare and Medicaid Services (CMS). The District received approval for the Tax Waiver on June 27, 2025, and SDP Preprint approval on September 9, 2025. The District made a first directed payment to Managed Care Providers (MCP) on October 20, 2025, for hospital claims incurred and paid through August 31, 2025. Lastly, the District included the approved provider tax in assessments sent to hospitals for the first quarter of FY 2026.

The FY2026 SDP and Tax Waiver are currently in review by CMS. The SDP Preprint, Tax Waiver, and corresponding documents were all submitted to CMS on June 30, 2025. The District has received and responded to CMS feedback on 3 occasions concerning the Preprint and once on the Tax Waiver.

b. Status of hiring for the FTE position at DHCF to administer this program.

The OCFO has hired and filled the Reimbursement position, which oversees the financial responsibilities of the Average Commercial Rate (ACR) analysis.

c. List of policy priorities funded through the District Retention as determined through collaboration with the Hospital Association and a plan for implementing the priorities.

The uses of the District Retention were established and codified through the FY25 budget process. The District retention was set aside to fund Medicaid fee-for- service payments to hospitals and hire an FTE to support implementation of the ACR. Please see table below for spending allocation in the FY25 and FY26.

Account Group Description	Account Description	FY2025 Budget	FY2026 Budget
CONTINUING FULL TIME	CONTINUING FULL TIME	\$57,008.05	\$33,191.95
FRINGE BENEFITS - CURR	MISCFRINGE BENEFITS	\$12,655.79	\$7,700.53
PERSONNEL			
TOTAL PERSONAL SERVICES		\$69,663.84	\$40,892.48
INPATIENT IN STATE	MEDICAL VENDOR SERVICES	\$8,688,549.00	
OUTPATIENT HOSPITAL	MEDICAL VENDOR SERVICES	\$12,518.00	
EMERGENCY MEDICAID	MEDICAL VENDOR SERVICES	\$4,470,555.00	
GOVERNMENT SUBSIDIES & GRANTS	MEDICAL VENDOR SERVICES		\$8,170,786.00

GOVERNMENT SUBSIDIES & GRANTS	MEDICAL VENDOR SERVICES		\$11,062,021.00
TOTAL HOSPITAL SPENDING		\$13,171,622.00	\$19,232,807.00
TOTAL RETENTION SPENDING		\$13,241,285.84	\$19,273,699.48

For the FY26 Budget, total District Retention was budgeted at \$19,232,807. These amounts were included within line items 70200-Managed Care Organizations (MCO) (HT0) cost centers and HT0.Inpatient Hospital Directed Payments Provider Fee Fund and HT0. Outpatient Hospital Directed Payments Provider Fee Fund projects. The line items totaled \$35,537,024.96 and \$52,826,215.26 for inpatient and outpatient, respectively. Additionally, FY 2026 BSA Title VII Subtitle I transferred \$5,031,741 of District Retention from the Outpatient Directed Payment Fund to the Local fund.

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38. Please provide the following data regarding the MCOs, including any changes from FY 2024 and reasons for the change for FY 2025 and FY 2026, to date:

- a. Eligibility requirements.**
- b. Services provided per MCO including value-add services; and**
- c. Reimbursement rates and methodologies per clinical specialty.**

Response

a. Eligibility requirements.

Effective October 2025, DHCF transitioned eligible persons enrolled in the DC Healthcare Alliance and Immigrant Children's Program from managed care and transitioned to Fee-for-service (FFS) Medicaid.

Effective October 2025, DHCF extended eligibility through the *CHIP Unborn Child* Option, renamed locally as From-Conception-to-End-of-Pregnancy (FCEP). This eligibility pathway extends coverage of prenatal, labor and delivery, and postpartum care to pregnant individuals up to 324% of the FPL. For additional eligibility requirements see [Pregnant Individuals](#)

Effective January 2026, Childless adults and parent/caregiver relatives ages 21 years and older with incomes at or above 138% of the federal poverty level (FPL) will no longer be eligible for Medicaid. [D.C. Medicaid Income Eligibility Changes Effective January 1, 2026](#)

b. Services provided per MCO including value-add services.

Each MCO delivers a core set of Medicaid-covered services listed here- [Medicaid Covered Services](#).

In FY2025, DHCF added Cell and Gene Therapies (CGT) and discontinued coverage for COVID-19 Testing Kits. The MCPs scope of coverage is outlined below.

New Cell and Gene Therapies (CGT)

Lyfgenia and Casgevy are FDA-approved CGT medications indicated for the treatment of sickle cell disease for patients aged 12 years and older. These medications must be administered exclusively at inpatient facilities that are qualified treatment centers. The Medicaid FFS program is responsible for reimbursement of approved inpatient CGT medications provided to eligible beneficiaries enrolled in DC Medicaid. The medication component of these therapies will be carved-out of the Diagnosis Related Treatment Group (DRG) bundled payment methodology and reimbursed separately under the fee-for service (FFS) Medicaid program.

MCPs are responsible for all other healthcare costs associated with CGTs, such as administration, inpatient stays, or other supportive care, like transportation. Providers must submit claims for these healthcare services directly to the beneficiaries' MCP for reimbursement. For CGTs administered on an outpatient basis, FFS also reimburses for the medication, while MCPs are responsible for all other treatment and support needs, for their enrollees.

COVID-19 Testing Kits

DHCF's authority to cover testing kits expired in September 2024, at which time DHCF requested a one-year extension. DHCF discontinued reimbursement for testing kits in September 2025.

FY2025 Value-added Benefits per Managed Care Plan

MCP	Value-Add Benefit	Description	Projected Enrollment Participation
AmeriHealth	Medically Tailored Meals/Groceries	Meal Delivery, Nutritionist Consult & Coaching	6300
	Respite Care with Temporary Housing	Temporary Housing with Care Coordination Post Inpatient Discharge	Unknown
	Healthy Housing Advocacy	Legal Assistance with Housing Conditions that Trigger Asthma	Unknown
	Chiropractic Services	Joint manipulation to reduce pain, correct alignment, and improve function.	Unknown
HSCSN	Fitness Training	Personal training up to 12 visits, ages 6 years and older.	200
	Home Modifications & Adaptions	Permanent alterations to support access, safety, and independence.	Unknown
	Medication Therapy Management	Expert, comprehensive, ongoing review of Enrollees' medication regimen by Pharmacists.	Unknown
	Paid Caregiver	Services typically provided by a Personal Care Aide but provided by a Natural Network member with training.	20

	Skilled Nursing for Caregiver Relief	Respite care for the family/caregiver.	120
	Summer Programs	Camps with varied focus dependent on the needs of the enrollee.	150
	Wellness Center	Access to Care Management services and a Benefits Manager, Educational Groups	Unlimited
MedStar Family Choice	Culinary and Nutrition Cooking Program	Nutrition consultation, Educational Workshops, Cooking Classes	130
	Community Wellness Center	Access to Care Management services and a Benefits Manager, Educational Groups	600
	Meal Delivery	18 meals per week for enrollees with 12 Qualifying conditions.	Unknown
	Tooth Care	Application of Silver Diamine Fluoride	Unknown
	The Goal Standard Fitness	Fitness Videos and Interactive Sessions	400
Wellpoint (formerly Amerigroup)	Active & Fit	Online Fitness Videos and Newsletters, Weight Watchers Vouchers, Gym Membership.	50% of enrollees
	Farm to Table Produce	Food delivery	6% of enrollees
	GED Assistance	Covers cost of the exam.	Unlimited

c. Reimbursement rates and methodologies per Clinical Specialty.

MCPs negotiate rates in agreements with Providers. The DHCF Medicaid Fee Schedule is a reference for negotiations.

**DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

General Question

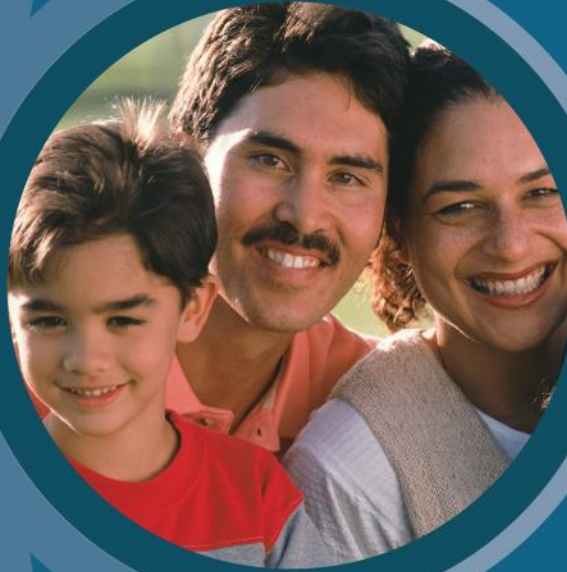
40. DHCF stated in its FY 2024 performance oversight responses that it is no longer transitioning beneficiaries, including children and youth in foster care, from fee for service to managed care. Please provide a rationale for this decision.

Response:

DHCF initially announced Medicaid reform efforts in 2019, with a focus of transitioning most Medicaid beneficiaries into the managed care delivery system over a five-year period. The first phase was executed in October 2020 when DHCF mandated that specific adult populations be enrolled in managed care.

Other efforts to require Medicaid enrollment into managed care, including children and youth in foster care and individuals receiving long-term services and supports, did not move forward because DHCF reprioritized efforts. This included developing and implementing a special needs plan for adults dually enrolled in Medicaid and Medicare (known as Dual Choice) and the program of all-inclusive care for the elderly (PACE). This path allowed DHCF to gain experience in establishing managed care or managed care-like programs for populations with special needs. Additionally, DHCF pursued carving-in behavioral health services into managed care, which was paused in February 2024.

District of Columbia
Department of Health Care Finance



District of Columbia Managed Care Programs

2024 Annual Technical Report

Qlarant 



Submitted by:
Qlarant
April 2025

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District of Columbia Managed Care Programs

2024 Annual Technical Report

Executive Summary

Introduction

The District of Columbia (DC or the District) Department of Health Care Finance (DHCF) aims to improve the health and well-being of DC residents by providing access to comprehensive, cost-effective, and quality health care services through multiple managed care programs. These programs, which serve more than 236,000 enrollees, include the DC Healthy Families Program (DCHFP), Child and Adolescent Supplemental Security Income Program (CASSIP), and District Dual Choice Program (DDCP). Table ES-1 highlights these programs and the contracted Managed Care Plans (MCPs) providing associated services.

Table.ES-1. DC Managed Care Programs

Managed Care Program	Contracted Managed Care Plan
DC Healthy Families Program (DCHFP). Established in 1994, the DCHFP provides acute, primary, specialty, and select behavioral health services to qualifying children, families, and pregnant women.	- AmeriHealth Caritas District of Columbia (ACDC) - Amerigroup District of Columbia (AGP)¹ - MedStar Family Choice (MFC)
Child and Adolescent Supplemental Security Income Program (CASSIP). Organized in 1996, the CASSIP provides acute, primary, specialty, and behavioral health services to qualifying children and youth with special health care needs who receive supplemental security income.	Health Services for Children with Special Needs (HSCSN)
District Dual Choice Program (DDCP). Established in 2022, the DDCP coordinates Medicare and Medicaid services, including long-term services and supports and behavioral health services, through a dual eligible special needs plan (D-SNP).	UnitedHealthcare Community Plan (UHC)

DHCF contracts with Qlarant, an external quality review organization (EQRO), to conduct annual, independent reviews of the District's MCPs, as required in the Code of Federal Regulations (42 CFR §438.350). As the DC EQRO, Qlarant evaluates MCP compliance with federal and DHCF-specific requirements by conducting multiple external quality review (EQR) activities including:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review also referenced as Operational Systems Review (OSR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Network Adequacy Survey Focus Study
- Maternal Health and Birth Outcomes Focus Study

¹ AGP's contract with DHCF commenced on April 1, 2023. AGP replaced CareFirst Community Health Plan District of Columbia (CFDC).

EQR activities were completed for *all* MCPs contracted with the District; no MCPs were exempt. This report summarizes results from EQR activities conducted throughout 2024 for the District's MCPs, and includes conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs. The evaluation assessed MCP compliance and performance for measurement years (MYs) 2023 and 2024, as applicable. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities.²

Key Findings

Summaries highlighting key findings and performance, for participating MCPs, are below. MCP-specific strengths, weaknesses, and recommendations are identified within the MCP Quality, Access, Timeliness Assessment section of the report.

Performance Improvement Project Validation. The MCPs conducted two PIPs each and reported performance measure results for MY 2023, as applicable. All MCPs were required to participate in a new Behavioral Health PIP and report baseline performance, as applicable. AGP was unable to report baseline performance due to its April 1, 2023 contract effective date. The MCP overall PIP validation scores ranged from 85.7%-100%. The DCHFP MCPs restarted their Maternal Health PIP. The MCPs reported baseline performance, as applicable. AGP was unable to report baseline performance. Overall validation scores ranged from 94.6%-100%. The CASSIP MCP, HSCSN, reported its second remeasurement results for the Childhood Obesity Management and Prevention PIP. The MCP achieved mixed results in the PIP measures and received an overall validation score of 84.0%. The DDCP D-SNP, UHC, reported its first remeasurement performance for the Fall Risk Management PIP and achieved an overall validation score of 100%.

Performance Measure Validation. Qlarant conducted two PMV audits during 2024. The first audit focused on validating the accuracy of select PIP and CMS Adult and Child Core Set measures. The second audit focused on validating the accuracy of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures. Information Systems Capabilities Assessments (ISCAs) determined MCPs had appropriate systems in place to process accurate claims and encounters, which were used to calculate performance measure rates. The participating MCPs received overall PMV ratings of 100% for the PIP and Core measures and 100% for the EPSDT measures. All measures were assessed as "reportable," as applicable. Separate from Qlarant's PMV audits, the MCPs participated in Healthcare Effectiveness Data and Information Set (HEDIS®) audits and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey activities. Performance measure results, on average, did not meet the national average benchmarks.^{3,4}

Operational Systems Review. Qlarant conducted a comprehensive OSR in 2024. The MCPs provided evidence of having operational systems, policies, and staff in place to support core processes necessary to deliver services to enrollees. MCP scores ranged from 96-100% (rounded from 99.72%). All MCPs 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.

² [CMS EQR Protocols](#)

³ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁴ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Network Adequacy Validation. All MCPs demonstrated stakeholders can have high confidence in how they calculate and report their compliance with the District’s provider network adequacy standards. All MCPs received a high confidence rating in each indicator they reported, except MFC received a moderate confidence rating in one pharmacy indicator. All MCPs failed to report all required indicators to DHCF. Each MCP omitted between three and 17 indicators. MCPs must include these indicators in their future reports. Reporting all required indicators provides DHCF with a complete picture of MCPs’ compliance levels.

Encounter Data Validation. A medical record review resulted in an overall encounter data accuracy rate of 94.5%—a 4.7 percentage point improvement over the previous annual MCP average of 89.8%. Individual MCP performance ranged from 90.9%-97.6%. Insufficient documentation in the medical record most frequently contributed to noncompliance. In these cases, the MCPs should educate their providers on including sufficient documentation in the medical records to support codes for billed claims.

Network Adequacy Survey Focus Study. All MCPs have robust provider networks and demonstrated compliance with geographic and provider-to-enrollee requirements, as applicable. During 2024, DCHFP and CASSIP MCP performance ranged from 77%-100% for timely access to routine and urgent care for both adults and children. Performance improved over the last year for adult access to routine and urgent appointments and pediatric access to routine and urgent appointments. Overall provider directory accuracy declined with the DCHFP and CASSIP MCP average dropping from 56% to 41% in MY 2024. The DDCP D-SNP was compliant with meeting the minimum number of providers for all LTSS provider types required by their contract with DHCF. UHC demonstrated a provider directory accuracy rate of 65% for LTSS provider listings. The DDCP D-SNP enrollees have access to home health agency covered services within 72 hours of acceptance of a referral. All MCPs, and particularly the DCHFP and CASSIP MCPs, should continue efforts to improve the reliability of provider directory content and ensure enrollees have access to accurate provider information.

Maternal Health and Birth Outcomes Focus Study. To better understand maternal health and birth outcomes within the District’s Medicaid managed care population, DHCF initiated a multiyear focus study. The focus study aims to answer the following questions: 1) To what extent are Medicaid managed care enrollees, who have given birth, receiving early and adequate prenatal care? 2) Do birth outcomes appear to correlate with the level of prenatal care received? 3) Do disparities exist in the adequacy of prenatal care and birth outcomes based on race/ethnicity and/or residence by ward? The first annual assessment was conducted in 2024. On average, 48% of Medicaid managed care enrollees received early and adequate prenatal care. Birth mothers aged 40-49 years were most frequently the recipients of this care. Correlations between early and adequate prenatal care and birth outcomes were identified by MCP, birth mother’s age, and District Ward. More than half of Medicaid managed care enrollee birth mothers reside in Wards 7 and 8, where early and adequate prenatal care rates were 49% and 45%, respectively. An analysis of race and ethnicity was not completed as a result of limitations in the data. The study will continue to identify trends and possible impacts of interventions.

Conclusion

Qlarant evaluated MCP compliance in providing Medicaid managed care enrollees with quality and timely access to care and concluded, on average, MCPs 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. The MCPs have worked to

move past challenges presented by the COVID-19 public health emergency. While PIP performance measure results were mixed, there were signs of improvement in timely access to PCP appointments. MCP HEDIS and CAHPS performance, on average, did not compare favorably to national average benchmarks. Opportunity exists to improve results in select measures, which support goals and objectives identified in DHCF's *Medicaid Managed Care Quality Strategy*.

Overall, MCPs improved compliance with structural and operational standards in the OSR. This improvement may be attributed to DHCF's enhanced quality improvement approach described in its *Managed Care Program Quality Management Manual*. DHCF is closely monitoring MCP performance and compliance, and as needed, holding MCPs accountable through corrective actions.

DHCF should continue to strive to improve District resident health outcomes by encouraging MCPs to meet and exceed quality strategy goals, and holding MCPs accountable for performance. DHCF's latest Medicaid Managed Care Quality Strategy (effective 2024-2027) specifies numerous objectives that include specific performance measures and targets that aim to ensure access to quality, whole-person care; improve management of chronic conditions; improve population health; ensure high-value, appropriate care for all Medicaid managed care enrollees; and improve clinician experience.

District of Columbia Managed Care Programs

2024 External Quality Review

Annual Technical Report

Introduction

Background

The District of Columbia (DC or District) Department of Health Care Finance (DHCF) administers DC's Medicaid managed care programs and aims to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for qualifying beneficiaries. DC's Medicaid population is diverse and includes individuals with complex medical, behavioral, and social needs. DC has developed multiple programs, over time, to effectively manage care and address the varied needs of the population.

DC Healthy Families Program (DCHFP). DCHFP, established in 1994, provides acute, primary, specialty, and select behavioral health services to qualifying children, families, and pregnant women through three risk-based managed care organizations (MCOs). Current MCOs include AmeriHealth Caritas District of Columbia (ACDC), Amerigroup District of Columbia (AGP), and MedStar Family Choice (MFC). DHCF's contract with CareFirst Community Health Plan District of Columbia (CFDC) ended on March 31, 2023. AGP replaced CFDC and commenced operations on April 1, 2023. The DCHFP serves approximately 217,847 enrollees.

Child and Adolescent Supplemental Security Income Program (CASSIP). CASSIP, organized as a Medicaid demonstration program in 1996, provides acute, primary, specialty, and behavioral health services to qualifying children and youth with special health care needs who receive supplemental security income. Enrollment into the single, prepaid benefit plan, Health Services for Children with Special Needs (HSCSN), is voluntary. The CASSIP serves approximately 4,913 enrollees.

District Dual Choice Program (DDCP). Established in 2022, the DDCP integrates care for dually eligible beneficiaries through a single program, which aims to improve Medicare and Medicaid benefit coordination. The DDCP includes a dual eligible special needs plan (D-SNP), in which enrollment is voluntary. The D-SNP provides Medicare and Medicaid services, including long-term services and supports (LTSS) and behavioral health services. UnitedHealthcare Community Plan of District of Columbia (UHC) is the single D-SNP providing these services and serves approximately 13,771 enrollees.

Collectively these entities, serving managed care enrollees, are referred to as managed care plans (MCPs) to maintain uniformity.

DHCF continues to transform its managed care program into a more organized, accountable, and person-centered system to best support the District's managed care enrollees in managing and improving their health. DHCF understands the significance of quality and its impact on health outcomes and requires the MCPs to attain and maintain National Committee for Quality Assurance (NCQA)

accreditation.⁵ NCQA evaluates health care quality provided to health plans members. The accreditation encompasses an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).^{6,7} Table 1 provides MCP NCQA accreditation status and other descriptive information.⁸

Table 1. MCP NCQA Accreditation Status

MCP	NCQA Health Plan Accreditation	NCQA Health Plan Rating	Other NCQA Accreditations, Certifications, and Distinctions	Next NCQA Review Date
ACDC	Accredited	3.0 out of 5 Stars	Health Equity Accreditation	8/3/27
AGP	Interim	Partial Data Reported	Health Equity Accreditation, Health Equity Accreditation Plus	4/8/25
HSCSN	Accredited	2.5 out of 5 Stars	None	5/11/27
MFC	Accredited	Partial Data Reported	None	11/11/25
UHC	Accredited	Partial Data Reported	None	1/7/28

Applicable NCQA programs and distinctions achieved by one or more MCPs are described below.

Health Equity Accreditation. This program offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.

Health Equity Accreditation Plus. This program offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities.

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires DHCF to contract with an external quality review organization (EQRO) to conduct annual, independent reviews of the District's MCPs. To meet these requirements, DHCF contracts with Qlarant. As the EQRO, Qlarant evaluates each MCP's compliance with federal and DC-specific requirements in a manner consistent with the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols. EQR activities were completed for *all* MCPs contracted with the District; no MCPs were exempt. During 2024, Qlarant conducted the EQR activities identified in Table 2.

⁵ Obtaining NCQA Health Plan Accreditation is a new requirement for HSCSN.

⁶ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁷ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

⁸ [NCQA Health Plan Report Card](#), accreditation status as of April 3, 2025.

Table 2. EQR Activities Conducted During 2024

EQR Activity During 2024	MCP Performance Period*
Performance Improvement Project (PIP) Validation	1/2023-12/2023
Performance Measure Validation (PMV) – PIP and CMS Core Measures - PMV - PIP and CMS Core Measures - PMV - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Measures	1/2023-12/2023 10/2023-9/2024
Compliance Review, also referenced as Operational Systems Review (OSR) - OSR - DCHFP and CASSIP - OSR - DDCP	1/2024-12/2024 1/2023-12/2023
Network Adequacy Validation (NAV)	1/2024-12/2024
Encounter Data Validation (EDV)	7/2022-6/2023
Network Adequacy Survey Focus Study	1/2024-12/2024
Maternal Health and Birth Outcomes Focus Study	10/2022-9/2023

* MCP performance period is the timeframe that was evaluated during the EQR activity. Qlarant evaluates the most current MCP information/data/results available for each EQR activity.

In addition to completing EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn regarding the quality, accessibility, and timeliness of care furnished by the MCPs. This Annual Technical Report summarizes Qlarant's EQR findings, based on MCP audits conducted during 2024 for each of the managed care programs. The report describes objectives, methodologies, results, and conclusions for each EQR activity. Qlarant identifies MCP strengths and weaknesses relating to quality, access, and timeliness of care provided to the managed care enrollees. Recommendations for improvement that, if acted upon, may positively influence enrollee outcomes and experiences, are also included.

Performance Improvement Projects

Objective

MCPs conduct PIPs as part of their quality assessment and performance improvement program, in accordance with 42 CFR §438.330(d). PIPs use a systematic approach to quality improvement and can be effective tools to assist MCPs in identifying barriers and implementing targeted interventions to achieve and sustain improvement in clinical outcomes or administrative processes. PIP EQR activities verify the MCP used sound methodology in its design, implementation, analysis, and reporting. PIP review and validation activities assess the MCP level of improvement and provide DHCF and other stakeholders a level of confidence in results.

Methodology

DHCF required all MCPs to conduct and report on two District-selected PIPs during 2024.

Description of Data Obtained. The MCPs documented measurement year (MY) 2023 PIP-related activities, improvement strategies, and results in their 2024 reports. Using Qlarant-developed reporting templates and worksheets, they submitted a separate report to Qlarant for each PIP topic in July 2024. The reports included validated performance measure results, data and barrier analyses, and identified PIP follow-up activities. Qlarant provided technical assistance to the MCPs, as requested.

Technical Methods of Data Collection and Analysis. Qlarant assessed a narrative report and calculations worksheet for each PIP report. Validation activities were completed in a manner consistent with the *CMS EQR Protocol 1 – Validation of Performance Improvement Projects*.⁹ PIP validation includes the following nine steps:

1. **Review the selected PIP topic.** Qlarant determines if the PIP topic targets an opportunity for improvement and is relevant to the MCP's population.
2. **Review the PIP aim statement.** Qlarant evaluates the adequacy of the PIP aim statement, which should frame the project and define the improvement strategy, population, and time period.
3. **Review the identified PIP population.** Qlarant determines whether the MCP identifies the PIP population in relation to the aim statement.
4. **Review the sampling method.** If the MCP studied a sample of the population, rather than the entire population, Qlarant assesses the appropriateness of the MCP's sampling technique.
5. **Review the selected PIP variables and performance measures.** Qlarant assesses whether the selected PIP variables are appropriate for measuring and tracking improvement. Performance measures should be objective and measurable, clearly defined, based on current clinical knowledge or research, and focused on enrollee outcomes.
6. **Review the data collection procedures.** Qlarant evaluates the validity and reliability of MCP procedures used to collect the data informing PIP measurements.
7. **Review data analysis and interpretation of PIP results.** Qlarant assesses the quality of data analysis and interpretation of PIP results. The review determines whether appropriate techniques were used and if the MCP analysis and interpretation were accurate.
8. **Assess the improvement strategies (interventions).** Qlarant assesses the appropriateness of interventions for achieving improvement. The effectiveness of an improvement strategy is determined by measuring changes in performance, according to the PIP's predefined measures. Data should be evaluated on a regular basis, and subsequently, interventions should be adapted based on what is learned.
9. **Assess the likelihood that significant and sustained improvement occurred.** Qlarant evaluates improvement by validating statistical significance testing results and assessing improvement compared to baseline performance.

Qlarant PIP reviewers evaluate each step by answering a series of applicable questions, consistent with protocol requirements. Reviewers seek additional information and/or corrections from MCPs, when needed, during the evaluation. Results of each step receive a numeric score. Table 3 displays the maximum available points per step.

⁹ [CMS EQR Protocols](#)

Table 3. PIP Scoring

PIP Step	Points Available
1. PIP Topic	5
2. PIP Aim Statement	5
3. PIP Population	5
4. Sampling Method	5
5. PIP Variables and Performance Measures	10
6. Data Collection Procedures	10
7. Data Analysis and Interpretation of Results	20
8. Improvement Strategies (Interventions)	20
9. Significant and Sustained Improvement	20
Total	100

For each PIP, Qlarant determines three validation ratings:

- **Overall Validation Rating.** The overall validation rating refers to Qlarant’s overall confidence in the MCP’s PIP process and results. All elements in PIP steps 1-9 are used to calculate the overall validation score.
- **Methodology Validation Rating.** The methodology validation rating refers to Qlarant’s confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. Elements assessed in PIP steps 1-8 are used to calculate the methodology validation score.
- **Significant Improvement Validation Rating.** The significant improvement validation rating refers to Qlarant’s overall confidence that the PIP produced evidence of significant improvement, based on performance measure results. Elements assessed in PIP step 9 are used to calculate the significant improvement validation score.

Qlarant uses the percentage of applicable points earned for each PIP validation step to calculate a score and determine a rating, or level of confidence. Qlarant’s validation rating system is identified below.

- ❖ 90.0% - 100%: high confidence in MCP results
- ❖ 75.0% - 89.9%: moderate confidence in MCP results
- ❖ 60.0% - 74.9%: low confidence in MCP results
- ❖ <60%: no confidence in MCP results

Results

Table 4 identifies each PIP required, by participating managed care program, for 2024 (MY 2023).

Table 4. Required PIPs by Program

2024 PIPs (MY 2023)	DCHFP	CASSIP	DDCP
PIP Topic 1	Behavioral Health	Behavioral Health	Behavioral Health
PIP Topic 2	Maternal Health	Childhood Obesity Management and Prevention	Fall Risk Management

PIP validation results for 2024 MCP-reported PIPs, including MY 2023 activities and performance measure results, are included in this report. Tables 5, 13, 19, and 23 highlight key elements of the DHCF-

selected PIPs. MCP improvement strategies and results for each PIP for the year under review follow each of these tables.

Behavioral Health PIP

Table 5 identifies key elements of the Behavioral Health PIP. All managed care programs (DCHFP, CASSIP, and DDCP) are participating in this PIP. The 2024 PIP submissions included baseline performance.

Table 5. Behavioral Health PIP Key Elements

2024 PIP (MY 2023)	Behavioral Health
Program	DCHFP, CASSIP, DDCP
MCPs	ACDC, AGP, HSCSN, MFC, UHC
Performance Measures	1. Follow-Up After Emergency Department Visit for Mental Illness within 7 Days 2. Follow-Up After Emergency Department Visit for Mental Illness within 30 Days 3. Follow-Up After Hospitalization for Mental Illness within 7 Days 4. Follow-Up After Hospitalization for Mental Illness within 30 Days
Measure Steward	NCQA
Population	Enrollees six years of age and older who: (1) had an emergency department visit for mental illness/intentional self-harm or (2) were hospitalized for mental illness/intentional self-harm
Aim	Will implementation of targeted educational and outreach interventions improve performance in follow-up visits for enrollees who had an emergency department visit or were hospitalized for mental illness or intentional self-harm during the measurement year?
Phase	Baseline*

* AGP did not report baseline performance due to its contract start date of April 1, 2023.

ACDC Interventions

The Behavioral Health PIP was a baseline submission and did not require MCP interventions.

ACDC PIP Measure Results

Table 6 displays the MCP's Behavioral Health PIP measure results for the baseline year. An assessment of improvement will be available in the next annual report.

Table 6. ACDC Behavioral Health PIP Measure Results

Performance Measure	Baseline Year MY 2023	Last Measurement Year	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Mental Illness				
Within 7 Days	26.37%	Not Applicable	Not Applicable	Not Applicable
Within 30 Days	43.28%	Not Applicable	Not Applicable	Not Applicable
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days	19.79%	Not Applicable	Not Applicable	Not Applicable
Within 30 Days	37.50%	Not Applicable	Not Applicable	Not Applicable

AGP Interventions

AGP did not interventions due to its contract start date of April 1, 2023. The MCP will report interventions after its baseline year.

AGP PIP Measure Results

AGP did not report baseline performance due to its contract start date of April 1, 2023. The MCP will report baseline performance in their next annual report. MY 2024 will serve as the PIP baseline year.

HSCSN Interventions

The Behavioral Health PIP was a baseline submission and did not require MCP interventions.

HSCSN PIP Measure Results

Table 7 displays the MCP's Behavioral Health PIP measure results for the baseline year. An assessment of improvement will be available in the next annual report.

Table 7. HSCSN Behavioral Health PIP Measure Results

Performance Measure	Baseline Year MY 2023	Last Measurement Year	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Mental Illness				
Within 7 Days	47.37%	Not Applicable	Not Applicable	Not Applicable
Within 30 Days	59.65%	Not Applicable	Not Applicable	Not Applicable
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days	20.00%	Not Applicable	Not Applicable	Not Applicable
Within 30 Days	35.00%	Not Applicable	Not Applicable	Not Applicable

MFC Interventions

The Behavioral Health PIP was a baseline submission and did not require MCP interventions.

MFC PIP Measure Results

Table 8 displays the MCP's Behavioral Health PIP measure results for the baseline year. An assessment of improvement will be available in the next annual report.

Table 8. MFC Behavioral Health PIP Measure Results

Performance Measure	Baseline Year MY 2023	Last Measurement Year	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Mental Illness				
Within 7 Days	9.73%	Not Applicable	Not Applicable	Not Applicable
Within 30 Days	15.95%	Not Applicable	Not Applicable	Not Applicable
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days	4.08%	Not Applicable	Not Applicable	Not Applicable
Within 30 Days	10.39%	Not Applicable	Not Applicable	Not Applicable

UHC Interventions

The Behavioral Health PIP was a baseline submission and did not require MCP interventions.

UHC PIP Measure Results

Table 9 displays the MCP's Behavioral Health PIP measure results for the baseline year. An assessment of improvement will be available in the next annual report.

Table 9. UHC Behavioral Health PIP Measure Results

Performance Measure	Baseline Year MY 2023	Last Measurement Year	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Mental Illness				
Within 7 Days	11.11%	Not Applicable	Not Applicable	Not Applicable
Within 30 Days	14.29%	Not Applicable	Not Applicable	Not Applicable
Follow-Up After Hospitalization for Mental Illness				
Within 7 Days	9.47%	Not Applicable	Not Applicable	Not Applicable
Within 30 Days	13.02%	Not Applicable	Not Applicable	Not Applicable

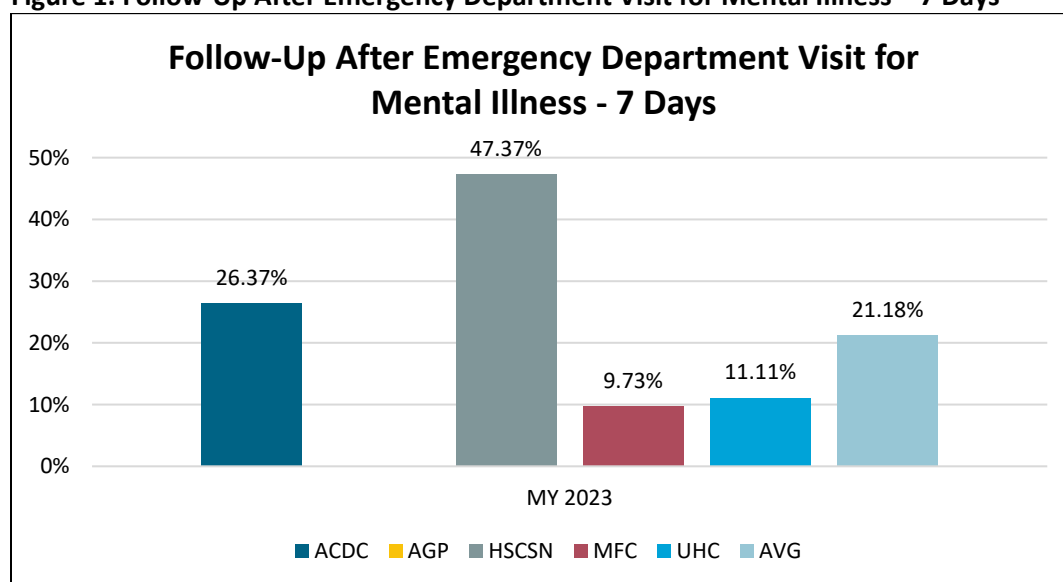
MCP Behavioral Health PIP Weighted Average Measure Results

Table 10 details MCP Behavioral Health PIP measure weighted averages for MY 2023.

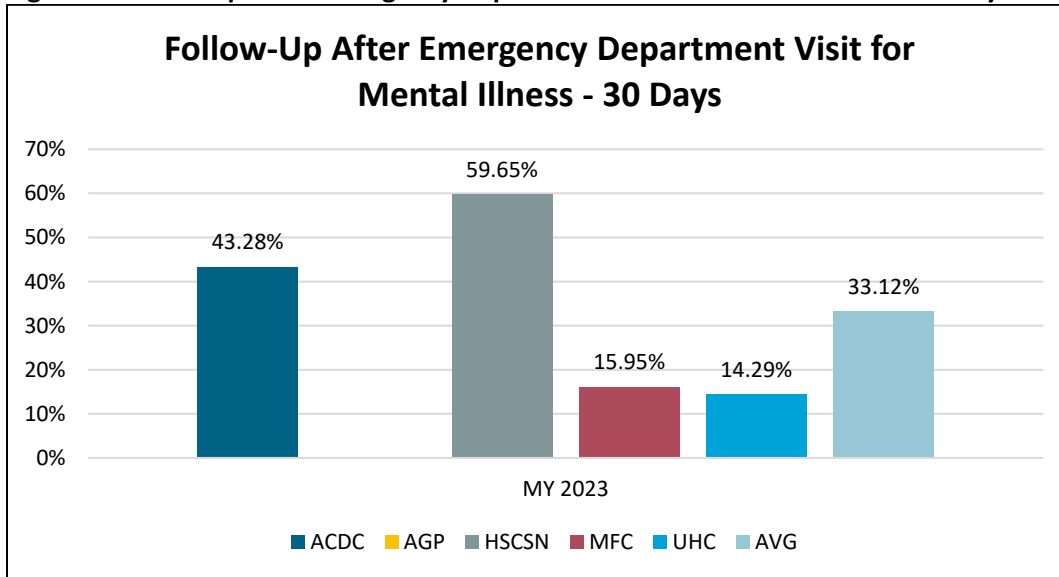
Table 10. MCP Weighted Averages – Behavioral Health PIP

Performance Measure	MY	Numerator	Denominator	MCP Weighted Average
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	2023	165	779	21.18%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	2023	258	779	33.12%
Follow-Up After Hospitalization for Mental Illness – 7 Days	2023	244	1,748	13.96%
Follow-Up After Hospitalization for Mental Illness – 30 Days	2023	466	1,748	26.66%

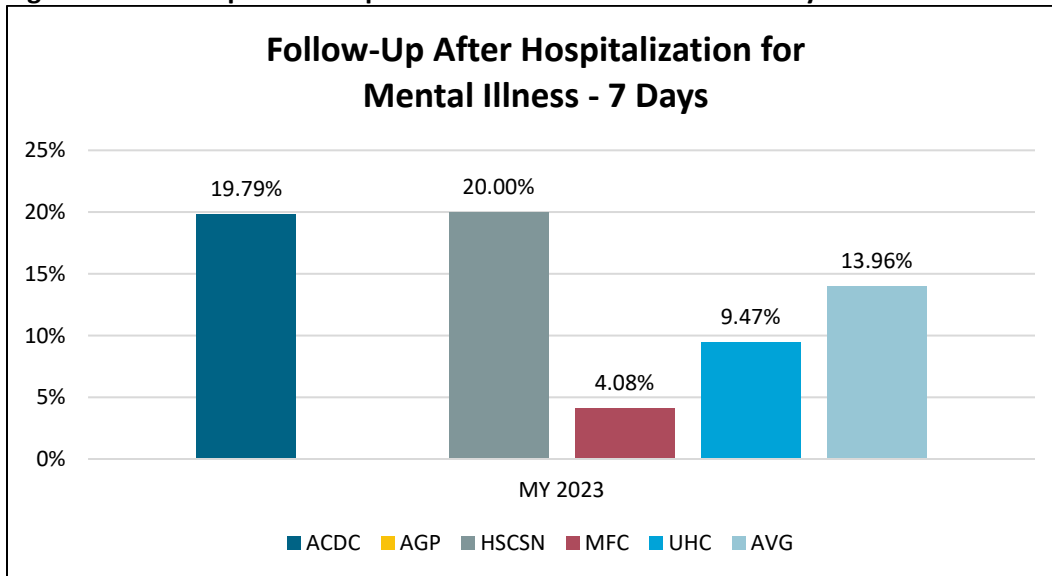
Figures 1-4 display baseline performance for each MCP for the Behavioral Health PIP measures. Additionally, the MCP weighted averages (shown as AVG) are included.

Figure 1. Follow-Up After Emergency Department Visit for Mental Illness – 7 Days

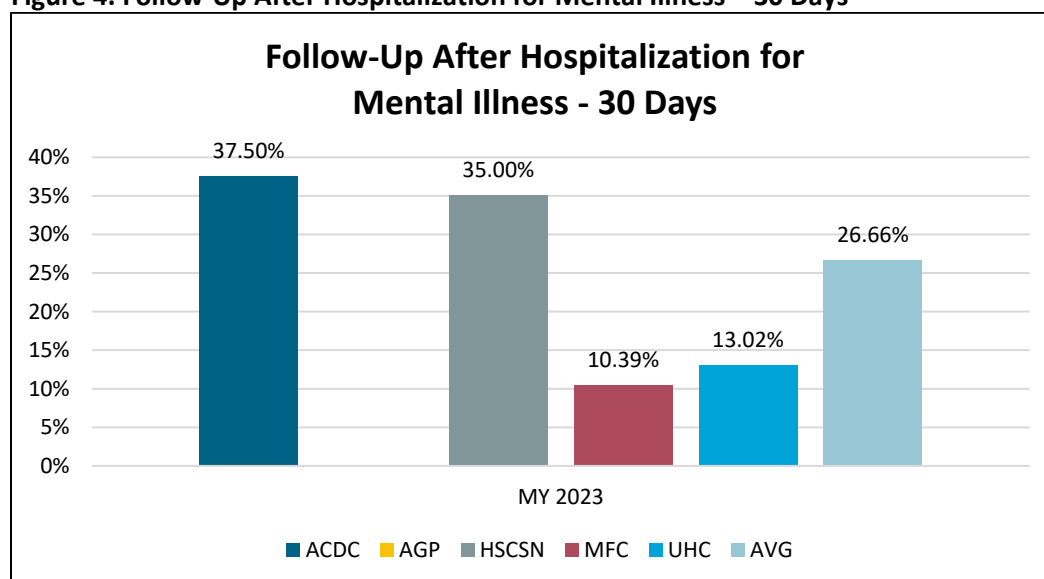
AGP did not report baseline performance due to its contract start date of April 1, 2023.

Figure 2. Follow-Up After Emergency Department Visit for Mental Illness – 30 Days

AGP did not report baseline performance due to its contract start date of April 1, 2023.

Figure 3. Follow-Up After Hospitalization for Mental Illness – 7 Days

AGP did not report baseline performance due to its contract start date of April 1, 2023.

Figure 4. Follow-Up After Hospitalization for Mental Illness – 30 Days

AGP did not report baseline performance due to its contract start date of April 1, 2023.

MCP PIP Validation Results

Table 11 includes MCP results for each PIP validation step for the Behavioral Health PIP.

Table 11. MCP PIP Validation Step Results – Behavioral Health PIP

PIP Validation Steps	ACDC	AGP	HSCSN	MFC	UHC
1. Topic	Met	Met	Met	Met	Met
2. Aim Statement	Met	Met	Met	Met	Met
3. Population	Met	Met	Met	Met	Met
4. Sampling Method	NA	NA	NA	NA	NA
5. Variables and Performance Measures	Met	Met	Met	Met	Met
6. Data Collection Procedures	Met	Partially Met	Met	Met	Met
7. Data Analysis and Interpretation of Results	Met	NA	Met	Met	Met
8. Improvement Strategies	NA	NA	NA	NA	NA
9. Significant and Sustained Improvement	NA	NA	NA	NA	NA

NA - Not applicable. Element under review did not apply, such as sampling; or the PIP is in the early phase of development and cannot be assessed on all requirements.

Table 12 includes 2024 overall validation ratings for each MCP's Behavioral Health PIP based on performance in Steps 1-9, as applicable. Overall performance ranges from 85.7% (AGP) to 100% (ACDC, HSCSN, MFC, and UHC).

Table 12. MCP Validation Ratings – Behavioral Health PIP

2024 PIPs (MY 2023)	ACDC	AGP	HSCSN	MFC	UHC	MCP Average
Overall	100% High Confidence 	85.7% Moderate Confidence 	100% High Confidence 	100% High Confidence 	100% High Confidence 	97.1% High Confidence 
Methodology	100% High Confidence 	85.7% Moderate Confidence 	100% High Confidence 	100% High Confidence 	100% High Confidence 	97.1% High Confidence 
Significant Improvement	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable

Rating/Level of confidence scale: High Confidence - 90.0% to 100%; Moderate Confidence - 75.0% to 89.9%; Low Confidence - 60.0% to 74.9%, No Confidence - <60.0%.

Maternal Health PIP

Table 13 identifies key elements of the Maternal Health PIP. Current participating MCPs include ACDC, AGP, and MFC. While this PIP has been ongoing for several years, DHCF elected to have the MCPs “restart” the PIP and use MY 2023 as a new baseline. This decision was made due to the changes in contracted MCPs and past performance that was impacted by the COVID-19 public health emergency.

Table 13. Maternal Health PIP Key Elements

2024 PIP (MY 2023)	Maternal Health
Programs	DCHFP
MCPs	ACDC, AGP, MFC
Performance Measures	Prenatal and Postpartum Care– 1. Timeliness of Prenatal Care 2. Postpartum Care
Measure Steward	NCQA
Population	Enrollees with live birth deliveries
Aim	Will implementation of system-level and targeted educational interventions increase the percentages of deliveries in which women had a timely prenatal visit and a timely postpartum visit during the measurement year?
Phase	Baseline*

*AGP did not report baseline performance due to its contract start date of April 1, 2023.

ACDC Interventions

The Maternal Health PIP was a baseline submission and did not require MCP interventions.

ACDC PIP Measure Results

Table 14 displays the MCP’s Maternal Health PIP measure results for the baseline year. An assessment of improvement will be available in the next annual report.

Table 14. ACDC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2023	Last Measurement Year	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.70%	Not Applicable	Not Applicable	Not Applicable
Postpartum Care	76.76%	Not Applicable	Not Applicable	Not Applicable

AGP Interventions

AGP did not interventions due to its contract start date of April 1, 2023. The MCP will report interventions after its baseline year.

AGP PIP Measure Results

AGP did not report baseline performance due to its contract start date of April 1, 2023. The MCP will report baseline performance in their next annual report. MY 2024 will serve as the PIP baseline year.

MFC Interventions

The Maternal Health PIP was a baseline submission and did not require MCP interventions.

MFC PIP Measure Results

Table 15 displays the MCP's Maternal Health PIP measure results for the baseline year. An assessment of improvement will be available in the next annual report.

Table 15. MFC Maternal Health PIP Measure Results

Performance Measure	Baseline Year MY 2023	Last Measurement Year	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	75.80%	Not Applicable	Not Applicable	Not Applicable
Postpartum Care	68.62%	Not Applicable	Not Applicable	Not Applicable

DCHFP MCP Maternal Health Weighted Average Measure Results

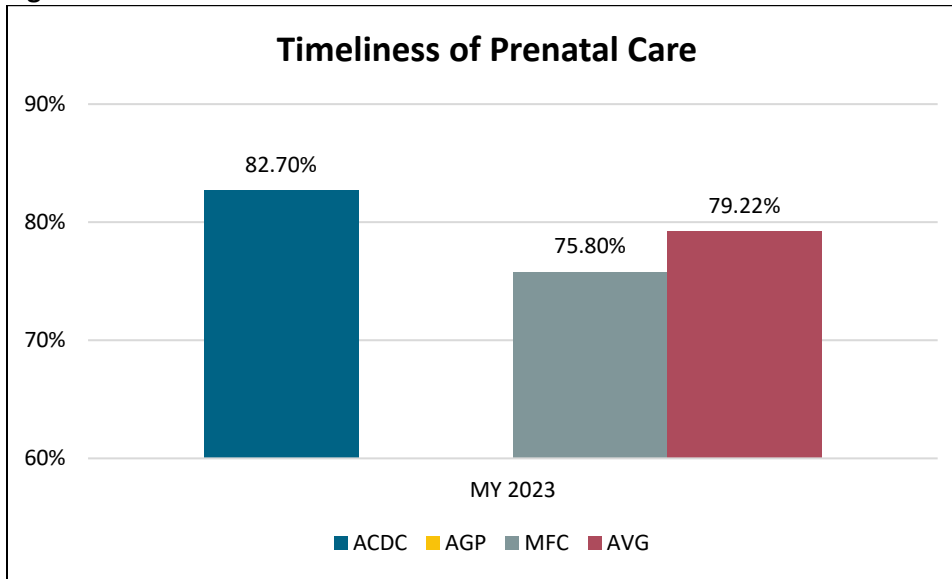
Table 16 details DCHFP MCP Maternal Health PIP measure weighted averages for MY 2023.

Table 16. MCP Weighted Averages – Maternal Health PIP

Performance Measure	Baseline Year MY 2023	Last Measurement Year	Improvement	Statistically Significant Improvement
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	2023	591	746	79.22%
Postpartum Care	2023	542	746	72.65%

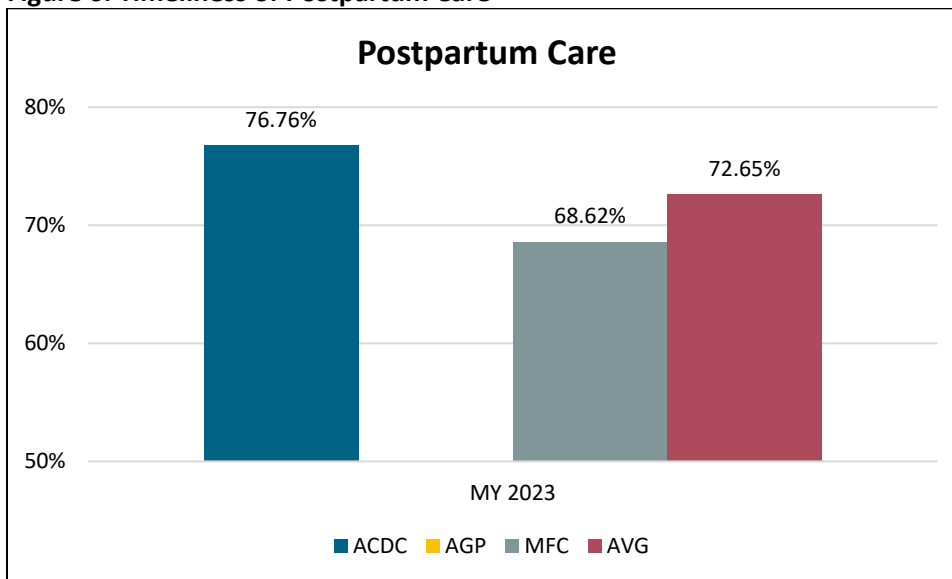
Figures 5-6 display baseline performance for each MCP for the Maternal Health PIP measures. Additionally, the MCP weighted averages (shown as AVG) are included.

Figure 5. Timeliness of Prenatal Care



AGP did not report baseline performance due to its contract start date of April 1, 2023.

Figure 6. Timeliness of Postpartum Care



AGP did not report baseline performance due to its contract start date of April 1, 2023.

DCHFP MCP PIP Validation Results

Table 17 includes DCHFP MCP results for each PIP validation step for the Maternal Health PIP.

Table 17. DCHFP MCP PIP Validation Step Results - Maternal Health PIP

PIP Validation Steps	ACDC	AGP	MFC
1. Topic	Met	Met	Met
2. Aim Statement	Met	Met	Met
3. Population	Met	Met	Met
4. Sampling Method	Met	Not Applicable	Met
5. Variables and Performance Measures	Met	Met	Partially Met
6. Data Collection Procedures	Met	Met	Met
7. Data Analysis and Interpretation of Results	Met	Not Applicable	Met
8. Improvement Strategies	Not Applicable	Not Applicable	Not Applicable
9. Significant and Sustained Improvement	Not Applicable	Not Applicable	Not Applicable

NA - Not applicable. Element under review did not apply, such as sampling; or the PIP is in the early phase of development and cannot be assessed on all requirements.

Table 18 includes 2024 overall validation ratings for each DCHFP MCP's Maternal Health PIP based on performance in Steps 1-9, as applicable. Overall performance ranges from 94.6% (MFC) to 100% (ACDC and AGP).

Table 18. MCP Validation Ratings – Maternal Health PIP

2024 PIPs (MY 2023)	ACDC	AGP	MFC	MCP Average
Overall	100% High Confidence 	100% High Confidence 	94.6% High Confidence 	98.2% High Confidence 
Methodology	100% High Confidence 	100% High Confidence 	94.6% High Confidence 	98.2% High Confidence 
Significant Improvement	Not Applicable	Not Applicable	Not Applicable	Not Applicable

Rating/Level of confidence scale: High Confidence - 90.0% to 100%; Moderate Confidence - 75.0% to 89.9%; Low Confidence - 60.0% to 74.9%, No Confidence - <60.0%.

Childhood Obesity Management and Prevention PIP

Table 19 identifies key elements of the Childhood Obesity Management and Prevention PIP. HSCSN is the only participating MCP.

Table 19. Childhood Obesity Management and Prevention PIP Key Elements

2024 PIP (MY 2023)	Childhood Obesity Management and Prevention
Program	CASSIP
MCP	HSCSN
Performance Measures	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— 1. Body Mass Index (BMI) Percentile Documentation (3-11 Years, 12-17 Years, Total) 2. Counseling for Nutrition (3-11 Years, 12-17 Years, Total) 3. Counseling for Physical Activity (3-11 Years, 12-17 Years, Total) Child and Adolescent Well-Care Visits— 4. Well-Care Visits (3-11 Years, 12-17 Years, 18-21 Years, Total)
Measure Steward	NCQA
Population	Measures 1-3: Enrollees 3-17 years of age who had an outpatient visit with a PCP or OB/GYN Measure 4: Enrollees 3-21 years of age
Aim	Will member, provider, and MCP interventions improve performance, over the measurement year, in the following PIP measures? • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (for enrollees ages 3-17 years of age) • Child and Adolescent Well-Care Visits (for enrollees ages 3-21 years of age)
Phase	Remeasurement 2

HSCSN Interventions

HSCSN completed several targeted enrollee, provider, and MCP interventions. Interventions addressed root causes or barriers to improvement. They were assessed as reasonable and likely to lead to improvement in processes or outcomes. A sample of interventions include:

- **Enrollee wellness incentive program.** Notified enrollees through educational material in the form of text and website letters to promote financial incentives for enrollee wellness.
- **Appointment scheduling.** Conducted Care Navigation telephonic outreach to schedule enrollee appointments with their preferred PCP.
- **Provider training.** Held virtual training on utilization of Z-codes. Held an annual continuing education conference in June 2023, which focused solely on the new obesity clinical practice guideline.
- **Value based care arrangements.** Multidisciplinary group at Children’s National Hospital met monthly to drive improvement in Well-Care Visit rates. Interventions included building direct connections between school nurses (DC public and public charter schools) and HSCSN, establishing a direct scheduling link between HSCSN and the Children’s National Call Center (which schedules for these provider groups).
- **Enrollee outreach.** Continued a Care Support Specialist workflow process with hard to reach enrollees to engage them in care.

HSCSN PIP Measure Results

Table 20 displays HSCSN’s Childhood Obesity Management and Prevention PIP measure results and level of improvement.

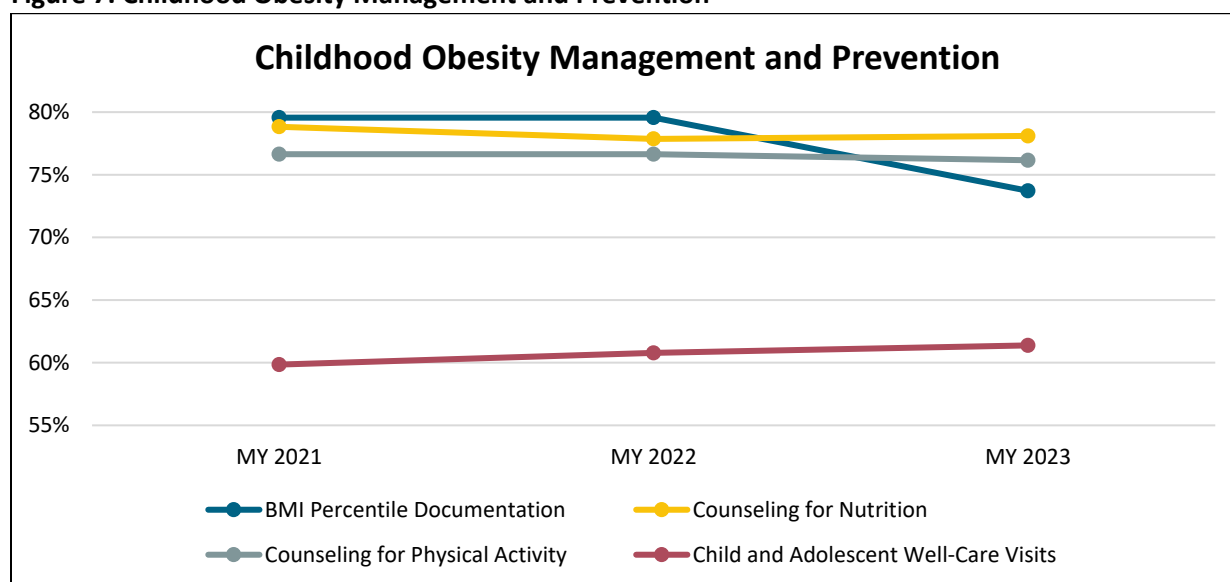
Table 20. HSCSN Childhood Obesity Management and Prevention PIP Measure Results

Performance Measure	Baseline Year MY 2021	Last Measurement Year MY 2023	Improvement	Statistically Significant Improvement
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile – 3-11 Yrs	80.54%~	77.23%	No	No
BMI Percentile – 12-17 Yrs	78.42%~	70.33%	No	No
BMI Percentile – Total	79.56%~	73.72%	No	No
Counseling for Nutrition – 3-11 Yrs	77.38%~	80.69%	Yes	No
Counseling for Nutrition – 12-17 Yrs	80.53%~	75.60%	No	No
Counseling for Nutrition – Total	78.83%~	78.10%	No	No
Counseling for Physical Activity – 3-11 Yrs	74.66%~	77.72%	Yes	No
Counseling for Physical Activity – 12-17 Yrs	78.95%~	74.64%	No	No
Counseling for Physical Activity – Total	76.64%~	76.16%	No	No
Child and Adolescent Well-Care Visits				
Well-Care Visits – 3-11 Yrs	65.18%~	68.21%	Yes	No
Well-Care Visits – 12-17 Yrs	61.37%~	63.03%	Yes	No
Well-Care Visits – 18-21 Yrs	47.27%~	45.22%	No	No
Well-Care Visits – Total	59.85%~	61.38%	Yes	No

~ Performance was likely influenced by the COVID-19 public health emergency.

HSCSN Annual Rates for the Childhood Obesity Management and Prevention PIP Measures

Figure 7 displays HSCSN annual performance rates for the Childhood Obesity Management and Prevention PIP measures for MYs 2021-2023. Each measure rate represents the total for all ages.

Figure 7. Childhood Obesity Management and Prevention

HSCSN PIP Validation Results

Table 21 includes HSCSN results for each PIP validation step for the Childhood Obesity Management and Prevention PIP.

Table 21. HSCSN PIP Validation Step Results – Childhood Obesity Management and Prevention PIP

PIP Validation Steps	HSCSN
1. Topic	Met
2. Aim Statement	Partially Met
3. Population	Met
4. Sampling Method	Met
5. Variables and Performance Measures	Partially Met
6. Data Collection Procedures	Met
7. Data Analysis and Interpretation of Results	Partially Met
8. Improvement Strategies	Met
9. Significant and Sustained Improvement	Partially Met

Table 22 includes 2024 validation ratings for the CASSIP MCP's Childhood Obesity Management and Prevention PIP based on performance in Steps 1-9. Overall, HSCSN scored 84.0%.

Table 22. MCP Validation Ratings – Childhood Obesity Management and Prevention PIP

2024 PIPs (MY 2023)	HSCSN
Overall	84.0% Moderate Confidence 
Methodology	90.0% High Confidence 
Significant Improvement	60.0% Low Confidence 

Rating/Level of confidence scale: High Confidence - 90.0% to 100%; Moderate Confidence - 75.0% to 89.9%; Low Confidence - 60.0% to 74.9%, No Confidence - <60.0%.

Fall Risk Management PIP

Table 23 identifies key elements of the Fall Risk Management PIP. UHC is the only participating MCP.

Table 23. Fall Risk Management PIP Key Elements

2024 PIP (MY 2023)	Fall Risk Management
Program	DDCP
MCP	UHC
Performance Measures	Screening, Risk Assessment, and Plan of Care to Prevent Future Falls— 1. Falls Screening 2. Falls Risk Assessment 3. Plan of Care
Measure Steward	CMS (Screening, Risk Assessment, and Plan of Care to Prevent Future Falls)
Population	Screening, Risk Assessment, and Plan of Care to Prevent Future Falls: Medicaid Managed Long-Term Services and Supports (MLTSS) participants 18 years of age and older.
Aim	Will implementation of a comprehensive assessment and fall risk management plan decrease the number of falls for enrollees 18 years of age and older with a history of falls during the measurement year?
Phase	Remeasurement 1

UHC Interventions

UHC completed several targeted enrollee, provider, and MCP interventions. Interventions addressed root causes or barriers to improvement. They were assessed as reasonable and likely to lead to improvement in processes or outcomes. A sample of interventions include:

- **Fall safety education.** Provided fall safety education upon the completion of fall risk assessments.
- **Fall prevention education.** Promoted and made referrals to an exercise program, physical therapy/occupational therapy, and/or balance/gait training, as appropriate.
- **Enhanced screening.** Added new questions specific to falls to the Core Adult Assessment to screen for falls and to cue the need for additional assessments and interventions, when appropriate.
- **Improved documentation.** Enhanced the care management system to facilitate ease of documentation on care manager assessments and plans of care.
- **Referrals for interventions and aides.** Made referrals to providers for lifestyle intervention on the need for physical therapy/occupational therapy services, durable medical equipment, or home modifications.

UHC PIP Measure Results

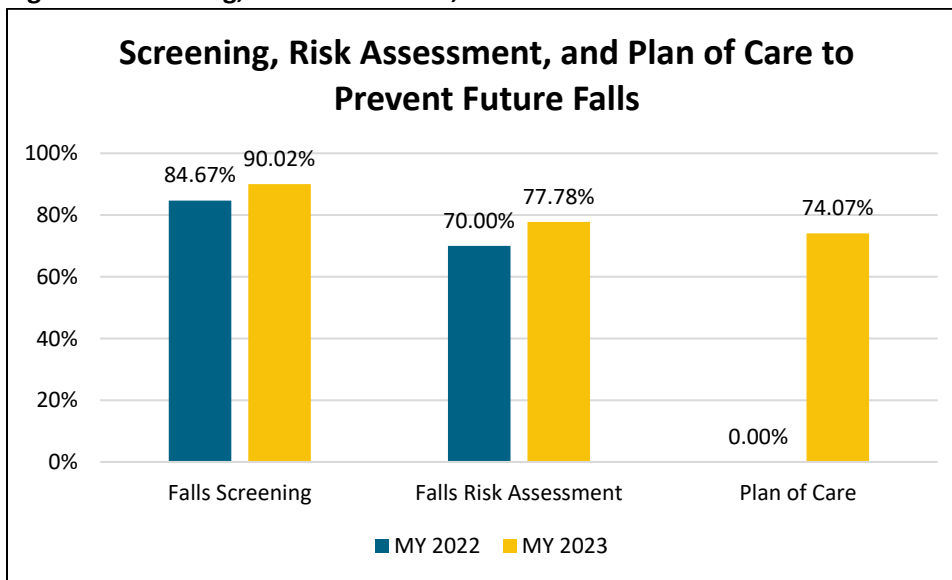
Table 24 displays UHC's Fall Risk Management PIP measure results and level of improvement.

Table 24. UHC Fall Risk Management PIP Measure Results

Performance Measure	Baseline Year MY 2022	Last Measurement Year MY 2023	Improvement	Statistically Significant Improvement
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls				
Falls Screening	84.67%	90.02%	Yes	Yes
Falls Risk Assessment	70.00%	77.78%	Yes	No
Plan of Care	0.00%	74.07%	Yes	Yes

UHC Annual Rates for the Fall Risk Management PIP Measures

Figure 8 displays UHC annual performance rates for the Fall Risk Management PIP measures for MYs 2022-2023.

Figure 8. Screening, Risk Assessment, and Plan of Care to Prevent Future Falls

UHC PIP Validation Results

Table 25 includes UHC results for each PIP validation step for the Fall Risk Management PIP.

Table 25. UHC PIP Validation Step Results – Fall Risk Management PIP

PIP Validation Steps	UHC
1. Topic	Met
2. Aim Statement	Met
3. Population	Met
4. Sampling Method	Met
5. Variables and Performance Measures	Met
6. Data Collection Procedures	Met
7. Data Analysis and Interpretation of Results	Met
8. Improvement Strategies	Met
9. Significant and Sustained Improvement	Met

NA – Not applicable. Element under review did not apply, such as sampling; or the PIP is in the early phase of development and cannot be assessed on all requirements.

Table 26 includes 2024 validation ratings for the DDCP MCP's Fall Risk Management PIP based on performance in Steps 1-9. Overall, UHC scored 100%.

Table 26. MCP Validation Ratings – Fall Risk Management PIP

2024 PIPs (MY 2023)	UHC
Overall	100% High Confidence 
Methodology	100% High Confidence 
Significant Improvement	100% High Confidence 

Rating/Level of confidence scale: High Confidence - 90.0% to 100%; Moderate Confidence - 75.0% to 89.9%; Low Confidence - 60.0% to 74.9%, No Confidence - <60.0%.

Conclusion

Summary conclusions for the DCHFP, CASSIP, and DDCP PIPs are below. Specific MCP strengths, weaknesses, and recommendations are included in the [MCP Quality, Access, Timeliness Assessment](#) section, in Tables 60-64, later in the report.

Behavioral Health PIP

- All MCPs reported baseline performance for the Behavioral Health PIP, which focuses on follow-up care after an emergency department visit or hospitalization for mental illness. AGP was the one exception due to their April 1, 2023 contract start date.
- All MCPs completed a barrier analysis and identified member, provider, and MCP barriers to target with interventions.
- All MCPs received high confidence ratings for their Behavioral Health PIP; except AGP, which received a moderate confidence rating.

Maternal Health PIP

- The DCHFP MCPs participated in the Maternal Health PIP and reported baseline performance. AGP was the one exception due to their April 1, 2023 contract start date. Performance measures focus on timely prenatal and postpartum care.
- The MCPs completed a barrier analysis and identified member, provider, and MCP barriers to target with interventions.
- All MCPs received high confidence ratings for their Maternal Health PIP.

Childhood Obesity Management and Prevention PIP

- HSCSN reported its second remeasurement performance for the Childhood Obesity Management and Prevention PIP.
- Measures focus on weight assessment and counseling for nutrition and physical activity, and well-care visits for children and adolescents.
- The MCP implemented interventions that target barriers to improvement.
- Performance was mixed. When reviewing performance in measures that calculated totals (all ages combined), the MCP only improved in the Child and Adolescent Well-Care Visits measure.
- HSCSN received an overall moderate confidence rating for the Childhood Obesity Management and Prevention PIP.

Fall Risk Management PIP

- UHC reported its first remeasurement performance in the Fall Risk Management PIP.
- Measures focus on fall risk management, including screens, assessments, and prevention.
- The MCP implemented interventions that target barriers to improvement.
- UHC received an overall high confidence rating for the Fall Risk Management PIP.

Performance Measure Validation

Objective

DHCF uses performance measures to monitor the performance of individual MCPs at a point in time, track performance over time, and compare performance among MCPs. DHCF requires MCPs to calculate and report measures as part of their quality assessment and performance improvement program, in accordance with 42 CFR §438.330(c). The PMV activity evaluates the accuracy and reliability of measures produced and reported by the MCP and determines the extent to which the MCP followed specifications for calculating and reporting the measures. Accuracy and reliability of the reported rates are essential to ascertain whether the MCP's quality improvement efforts resulted in improved health outcomes. Further, the validation process allows DHCF to have confidence in MCP measure results.

Methodology

Qlarant validated performance measures, including select MY 2023 PIP and CMS Core Set measures and fiscal year (FY) 2024 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures.¹⁰

Description of Data Obtained. Information from several sources was used to satisfy validation requirements. These sources included, but were not limited to, the following documents and information provided by the MCP:

- Information Systems Capabilities Assessment
- HEDIS Record of Administration, Data Management and Processes (Roadmap)
- HEDIS Final Audit Report, if available
- EPSDT policies and training materials, as applicable
- Other documentation (e.g. specifications, data dictionaries, program source code, data queries, policies, and procedures)
- Demonstrations during the site visit
- Interviews with MCP staff
- Information submitted as part of the follow-up items requested after the onsite visit

Technical Methods of Data Collection and Analysis. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 2 – Validation of Measures*.¹¹

The validation process was interactive and concurrent to the MCP calculating the measures. Validation activities occurred before, during, and after an onsite visit to the MCP and included two principle components:

- An overall assessment of the MCP's information systems (IS) capability to capture and process data required for reporting.
- An evaluation of the MCP's processes (e.g. source code programs) used to prepare each measure.

Essential PMV activities included:

- Review of the MCP's data systems and processes used to construct the measures.
- Assessment of the calculated rates for algorithmic compliance to required specifications.
- Verification the reported rates were reliable and based on accurate sources of information.

Qlarant conducted onsite PMV review activities in May 2024 for the PIP and Core Set measures and in October 2024 for EPSDT measures. MCP onsite PMV review activities were conducted via virtual desk audit. After approving final rates, Qlarant reported findings for the following audit elements, including documentation (data integration and control and calculation process), denominator, numerator, sampling (as applicable), and reporting. Audit element descriptions are provided below.

Documentation. Assessment of data integration and control procedures determine whether the MCP had appropriate processes and documentation in place to extract, link, and manipulate data for accurate and reliable measure rate construction. The evaluation includes reviewing and assessing documentation

¹⁰ District of Columbia FY 2024: October 1, 2023 through September 30, 2024.

¹¹ [CMS EQR Protocols](#)

of measurement procedures and programming specifications, including data sources, programming logic, and source codes.

Denominator. Validation of measure denominator calculations assesses the extent to which the MCP used appropriate and complete data to identify the entire population and the degree to which the MCP followed measure specifications for calculating the denominator.

Numerator. Validation of the numerator determines if the MCP correctly identified and evaluated all qualifying medical events for appropriate inclusion or exclusion in the numerator for each measure and if the MCP followed measure specifications for calculation of the numerator.

Sampling. Evaluation of sample size and replacement methodology specifications confirm the sample was not biased, if applicable.

Reporting. Validation of measure reporting confirms if the MCP followed DHCF specifications.

Qlarant calculated a validation rating for the MCP, based on audit element findings. The rating provides a level of confidence in the MCP's reported measure results. Validation ratings include:

- ❖ 95% - 100%: high confidence in MCP results
- ❖ 85% - 94%: moderate confidence in MCP results
- ❖ 75% - 84%: low confidence in MCP results
- ❖ <75%: no confidence in MCP results

Results

AGP's PIP and Core Measure PMV audit was limited due to its contract start date of April 1, 2023. The MCP did not report rates for MY 2023. UHC is not required to participate in the EPSDT PMV audit, as it does not report EPSDT performance measures.

PIP and Core Set Performance Measure Validation Results

All MCPs had appropriate systems in place to process accurate claims and encounters. Table 27 includes 2024 MCP PMV results, based on the calculation of select PIP and CMS Core Set measures. Compliance with each PMV element is reported by MCP and MCP average.

Table 27. PIP and Core Set Measure PMV Results

Element	ACDC	AGP	HSCSN	MFC	UHC	MCP Average
Data Integration and Control	100%	100%	100%	100%	100%	100%
Data and Process Used to Produce Measures	100%	100%	100%	100%	100%	100%
Denominator	100%	100%	100%	100%	100%	100%
Numerator	100%	100%	100%	100%	100%	100%
Sampling	100%	100%	100%	100%	100%	100%
Reporting	100%	100%	100%	100%	100%	100%
Overall Rating	100%	100%	100%	100%	100%	100%
Reporting Designation	R	NA	R	R	R	R
Level of Confidence	High 	High 	High 	High 	High 	High 

R - Reportable; measures were compliant with DHCF specifications.

NA - Not applicable; AGP did not report rates due to its April 1, 2024 contract effective date.

Rating/Level of confidence scale: High Confidence - 95% to 100%; Moderate Confidence - 85% to 94%; Low Confidence - 75% to 84%, No Confidence - <75%.

Table 28 displays select PIP performance measures and CMS Core Measure rates, and reports each performance measure's data collection methodology. The DC average and benchmark are provided for each measure, as applicable. The DC average is based only on the reporting MCPs and is not weighted.

Table 28. PIP and Core Measure Performance Measure Results for MY 2023

Abbr	Performance Measure	Data ⁺	ACDC %	AGP %	HSCSN %	MFC %	UHC %	DC AVG %	Benchmark*
BPD/CDC	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	A	53.28	--	69.44	59.61	73.72	64.01	
CCP-AD	Contraceptive Care – Postpartum Women Ages 21-44 LARC Method of Contraception 3 Days	A	3.53	--	NA	3.56	NA	3.55	
CCP-AD	Contraceptive Care – Postpartum Women Ages 21-44 LARC Method of Contraception 90 Days	A	13.01	--	NA	15.37	NA	14.19	

Abbr	Performance Measure	Data ⁺	ACDC %	AGP %	HSCSN %	MFC %	UHC %	DC AVG %	Benchmark*
CCP-AD	Contraceptive Care – Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception 3 Days	A	12.46	--	NA	9.80	NA	11.13	♦ ♦
CCP-AD	Contraceptive Care – Postpartum Women Ages 21-44 Most or Moderately Effective Method of Contraception 90 Days	A	45.09	--	NA	42.32	NA	43.70	♦ ♦
CCP-CH	Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 3 Days	A	1.25	--	NA	6.00	NA	3.63	♦ ♦
CCP-CH	Contraceptive Care – Postpartum Women Ages 15-20 LARC Method of Contraception 90 Days	A	15.00	--	NA	22.00	NA	18.50	♦ ♦
CCP-CH	Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 3 Days	A	3.75	--	NA	12.00	NA	7.88	♦ ♦ ♦
CCP-CH	Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 90 Days	A	46.25	--	NA	46.00	NA	46.13	♦ ♦
CCW-AD	Contraceptive Care – All Women Ages 21–44 LARC Method of Contraception	A	3.11	--	NA	10.02	NA	6.56	♦ ♦ ♦
CCW-AD	Contraceptive Care – All Women Ages 21–44 Most or Moderately Effective Method of Contraception	A	20.69	--	NA	42.69	NA	31.69	♦ ♦ ♦
CCW-CH	Contraceptive Care – All Women Ages 15-20 LARC Method of Contraception	A	3.03	--	2.32	3.81	NA	3.05	♦ ♦

Abbr	Performance Measure	Data ⁺	ACDC %	AGP %	HSCSN %	MFC %	UHC %	DC AVG %	Benchmark*
CCW-CH	Contraceptive Care – All Women Ages 15-20 Most or Moderately Effective Method of Contraception	A	20.43	--	25.99	16.03	NA	20.82	♦
COB-AD	Concurrent Use of Opioids and Benzodiazepines <i>(lower rate is better)</i>	A	6.72	--	NA	5.30	8.77	6.01	♦ ♦ ♦
DEV	Developmental Screening in the First Three Years of Life Total: Total number of eligible children who had a screening in the 12 months on or before their 1st, 2nd, or 3rd birthday	A	23.64	--	17.11	18.61	NA	19.79	♦
EED/CDC	Comprehensive Diabetes Care - Eye Exams	A	46.96	--	47.22	30.17	80.31	51.17	NBA
HBD/CDC	Comprehensive Diabetes Care - HbA1c Control (<8%)	A	51.82	--	36.11	52.31	71.05	52.82	♦ ♦
HBD/CDC	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) <i>(lower rate is better)</i>	A	39.42	--	61.11	40.15	21.41	40.52	♦
HDO	Use of Opioids at High Dosage in Persons Without Cancer <i>(lower rate is better)</i>	A	1.38	--	0.00	0.65	2.47	1.13	♦ ♦ ♦
ODU-AD	Use of Pharmacotherapy for Opioid Use Disorder, Ages 18-64: Total (Rate 1)	A	30.44	--	NA	60.00	22.60	37.68	♦
PPC	Prenatal and Postpartum Care: Postpartum Care	H	76.76	--	53.33	68.62	NA	66.24	♦
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	H	82.70	--	70.00	75.80	NA	76.17	♦ ♦

Abbr	Performance Measure	Data ⁺	ACDC %	AGP %	HSCSN %	MFC %	UHC %	DC AVG %	Bench-mark*
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile: 12-17 Yrs	A	77.78	--	70.33	58.12	NA	68.74	NBA
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile: 3-11 Yrs	A	76.15	--	77.23	64.68	NA	72.69	NBA
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile: Total	A	76.82	--	73.72	62.39	NA	70.98	♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: 12-17 Yrs	A	80.39	--	75.60	64.96	NA	73.65	NBA
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: 3-11 Yrs	A	74.77	--	80.69	70.18	NA	75.21	NBA
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: Total	H	77.09	--	78.10	68.36	NA	74.52	♦ ♦ ♦
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: 12-17 Yrs	A	77.78	--	74.64	58.12	NA	70.18	NBA
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: 3-11 Yrs	A	70.64	--	77.72	68.35	NA	72.24	NBA

Abbr	Performance Measure	Data ⁺	ACDC %	AGP %	HSCSN %	MFC %	UHC %	DC AVG %	Benchmark*
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: Total	H	73.58	--	76.16	64.78	NA	71.51	◆ ◆ ◆
WCV	Child and Adolescent Well-Care Visits: 12-17 Yrs	A	61.17	--	63.03	45.69	NA	56.63	◆ ◆ ◆
WCV	Child and Adolescent Well-Care Visits: 18-21 Yrs	A	36.22	--	45.22	23.22	NA	34.89	◆ ◆ ◆
WCV	Child and Adolescent Well-Care Visits: 3-11 Yrs	A	60.90	--	68.21	49.77	NA	59.63	◆ ◆
WCV	Child and Adolescent Well-Care Visits: Total (3-21)	A	57.20	--	61.38	44.63	NA	54.40	◆ ◆ ◆

+ Data Collection Method - Administrative data collection (A): rates are calculated using claims and other supplemental data. Hybrid data collection (H): rates are calculated using administrative and medical record data.

-- AGP did not report rates due to its April 1, 2023 contract effective date.

The DC average is not weighted.

NA - Not applicable. The measure is not applicable to the population or the denominator was too small (less than 30).

NBA - No benchmark available.

* Benchmark sources: Quality of Care for Adults in Medicaid: Findings from the 2023 Adult Core Set, Chart Pack, December 2024; Quality of Care for Children in Medicaid and CHIP: Findings from the 2023 Child Core Set, Chart Pack, December 2024.

◆ The DC MCP Average is below the national median.

◆ ◆ The DC MCP Average is equal to or exceeds the national median, but does not meet the top quartile.

◆ ◆ ◆ The DC MCP Average is equal to or exceeds the top quartile.

EPSDT Performance Measures

Qlarant completed a comprehensive EPSDT PMV audit for the DCHFP and CASSIP MCPs. Qlarant does not conduct an EPSDT audit for UHC, as the MCP does not report EPSDT measures.

All audited MCPs had appropriate systems in place to process accurate claims and encounters. Table 29 includes 2024 MCP PMV results, based on the calculation of FY 2024 EPSDT measures. Compliance with each PMV element is reported by MCP.

Table 29. EPSDT PMV Results

Element	ACDC	AGP	HSCSN	MFC	MCP Average
Data Integration and Control	100%	100%	100%	100%	100%
Data and Process Used to Produce Measures	100%	100%	100%	100%	100%
Denominator	100%	100%	100%	100%	100%
Numerator	100%	100%	100%	100%	100%
Sampling	NA	NA	NA	NA	NA
Reporting	100%	100%	100%	100%	100%
Overall Rating	100%	100%	100%	100%	100%
Reporting Designation	R	R	R	R	R
Level of Confidence	High 	High 	High 	High 	High 

NA – Not Applicable; sampling was not completed as the entire population was studied

R – Reportable; measures were compliant with DHCF specifications

Rating/Level of confidence scale: High Confidence - 95% to 100%; Moderate Confidence - 85% to 94%; Low Confidence - 75% to 84%, No Confidence - <75%.

Table 30 reports FY 2024 EPSDT measure results for each MCP.

Table 30. EPSDT Performance Measure Results

Performance Measure	ACDC	AGP	HSCSN	MFC
Total Individuals Eligible for EPSDT for 90 Continuous Days	48,425	23,976	4,448	23,326
Average Period of Eligibility	0.89	0.82	0.91	0.85
Expected Number of Screenings	52,951	24,310	4,363	24,628
Total Screens Received	36,450	15,391	3,390	14,642
Screening Ratio	0.69	0.63	0.78	0.59
Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	44,133	20,301	4,106	20,503
Total Eligibles Receiving at Least One Initial or Periodic Screen	27,340	11,181	2,871	10,873
Participation Ratio	0.62	0.55	0.70	0.53
Total Eligibles Referred for Corrective Treatment	12,008	4,625	2,685	3,278
Total Eligibles Receiving Any Dental Service From a Dentist	27,637	10,563	2,762	10,699
Total Eligibles Receiving Preventive Dental Service From a Dentist	23,348	9,589	2,568	9,795
Total Eligibles Who Received Dental Treatment Services From a Dentist	10,291	3,520	933	3,804
Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	2,799	1,344	254	1,243
Total Eligibles Receiving Diagnostic Dental Services	26,589	10,331	2,715	10,453

Performance Measure	ACDC	AGP	HSCSN	MFC
Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider	1,559	585	73	709
Total Eligibles Receiving Any Preventative Dental or Oral Health Service	24,106	10,698	2,582	10,097
Total Number of Screening Blood Lead Tests	3,918	1,428	174	1,403
Any Dental Services Ratio	0.57	0.44	0.62	0.46

Table 31 displays key FY 2024 EPSDT measure results, including screen, participation, and preventive dental service ratios. The table also reports the MCP weighted average for each key measure.

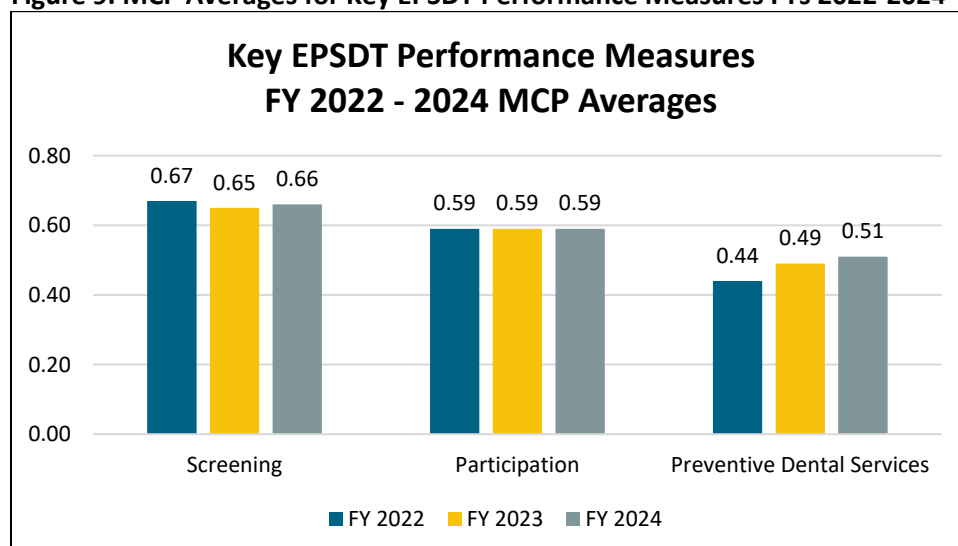
- **EPSDT Screening Ratio.** The calculation uses total screens received compared to the expected number of screens (for eligibles enrolled for 90 continuous days).
- **EPSDT Participation Ratio.** The calculation compares total eligibles who received at least one initial or periodic screen to total eligibles who should have received at least one initial or periodic screen.
- **Preventive Dental Services Ratio.** The calculation uses total eligibles receiving preventive dental services from a dentist compared to total eligibles who should receive at least one initial or periodic screen.

Table 31. FY 2024 Key EPSDT Performance Measure Results

Key EPSDT Performance Measures	ACDC	AGP	HSCSN	MFC	MCP Average
EPSDT Screening Ratio	0.69	0.63	0.78	0.59	0.66
EPSDT Participation Ratio	0.62	0.55	0.70	0.53	0.59
EPSDT Preventive Dental Services Ratio	0.53	0.47	0.63	0.48	0.51

Figure 9 displays key EPSDT measure results over the last three years, FYs 2022-2024.

Figure 9. MCP Averages for Key EPSDT Performance Measures FYs 2022-2024



Conclusion

Aggregate summary conclusions for the PMV activities are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 60-64 within the [MCP Quality, Access, Timeliness Assessment](#) section.

PIP and Core Measure PMV

- All MCPs had information systems capable of capturing and processing data required for reporting.
- All MCPs received an overall rating of 100 percent.
- Stakeholders can have high confidence in each MCP's performance measure calculations.
- The DC MCP averages exceeded national median benchmarks in 22 of 28 performance measures (79%). Of the 22 measures, 11 met or exceeded the top quartile benchmarks:
 - Contraceptive Care – Postpartum Women Ages 21-44 LARC Method of Contraception 3 Days
 - Contraceptive Care – Postpartum Women Ages 15-20 Most or Moderately Effective Method of Contraception 3 Days
 - Contraceptive Care – All Women Ages 21–44 LARC Method of Contraception
 - Contraceptive Care – All Women Ages 21–44 Most or Moderately Effective Method of Contraception
 - Concurrent Use of Opioids and Benzodiazepines
 - Use of Opioids at High Dosage in Persons Without Cancer
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: Total
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity: Total
 - Child and Adolescent Well-Care Visits: 12-17 Yrs
 - Child and Adolescent Well-Care Visits: 18-21 Yrs
 - Child and Adolescent Well-Care Visits: Total (3-21 Yrs)

EPSDT PMV

- All MCPs had information systems capable of capturing and processing data required for reporting.
- All MCPs received an overall rating of 100 percent; stakeholders can have high confidence in the MCPs' performance measure calculations.
- Key FY 2024 MCP average EPSDT measure ratios for screens, participation, and preventive dental services remained the same or improved, compared to FY 2023 performance. The screen ratio improved from 0.65 to 0.66. The participation ratio remained stable at 0.59. The preventive dental services ratio improved from 0.49 to 0.51. A positive three-year trend is noted in the preventive dental services measure.

Operational Systems Review

Objective

Operational systems reviews (OSRs), also referred to as compliance reviews, assess MCP compliance with structural and operational standards, which may influence the quality, timeliness, or accessibility of health care services provided to Medicaid enrollees. The comprehensive review determines compliance with federal and DHCF managed care program requirements. The review provides DHCF an independent assessment of MCP capabilities, which can be used to promote accountability and improve quality-related processes and monitoring.

Methodology

Qlarant conducted a comprehensive review of applicable CFR standards for the 2024 OSR. CFR standards (42 CFR §438) reviewed include:

- Subpart A §438.10: Information Requirements
- Subpart B §438.56: Disenrollment Requirements and Limitations
- Subpart C §438.100 - §438.114: Enrollee Rights and Protections
- Subpart D §438.206 - §438.242: MCO Standards
- Subpart E §438.330: Quality Assessment and Performance Improvement Program
- Subpart F §438.402 - §438.424: Grievance and Appeal System

Description of Data Obtained. Qlarant obtained MCP documentation to support compliance for the CFR standards. The DCHFP and CASSIP MCPs provided MY 2024 supporting documentation for the standards under review in August 2024. Qlarant review activities occurred before, during, and after the site visit to the MCPs in October 2024. The DDCP D-SNP was evaluated on a separate schedule. UHC submitted documentation in April 2024, and a site visit to the MCP followed in May 2024. UHC's review primarily focused on MY 2023 compliance.

Pre-site visit activities included evaluating policies, reports, meeting minutes, and other supporting documents obtained from each MCP. Qlarant conducted record reviews during the pre-site phase of the OSR, as well. Site visit activities focused on MCP staff interviews, process demonstrations, and follow up on record review findings. Post-site visit activities included an opportunity for the MCP to respond to preliminary findings and provide additional evidence of compliance, if available.

Technical Methods of Data Collection and Analysis. The 2024 OSR was conducted in a manner consistent with *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations*.¹² Qlarant conducted an interactive review with the MCP, and reviewed and scored all applicable elements and components of each standard requiring evaluation. Qlarant uses the following review determinations when evaluating MCP compliance for each element and/or component:

¹² [CMS EQR Protocols](#)

- **Met.** Demonstrates full compliance. 1 point. Documentation and data sources provide evidence of compliance and MCP staff are able to describe processes consistent with documentation provided, if applicable.
- **Partially Met.** Demonstrates at least some, but not full, compliance. 0.5 point. Documentation is present, but the staff is unable to articulate processes or show evidence of implementation during interviews, or staff is able to describe and verify the existence of processes, but documentation is incomplete or inconsistent with practice.
- **Not Met.** Does not demonstrate compliance on any level. 0 points. Documentation and data sources are not present or do not provide evidence of compliance, and staff is unable to describe and/or verify the existence of processes required to demonstrate compliance.
- **Not Applicable.** Requirement does not apply and is not scored.

Aggregate points earned are reported by standard and receive a compliance score based on the percentage of points earned. All assessments are weighted equally, which allows standards with more elements and components to have more influence on a final score. Finally, an overall OSR compliance score is calculated. Based on this overall score, a level of confidence in the MCP's OSR results is determined. Compliance ratings include:

- ◆ 95% - 100%: high confidence in MCP compliance
- ◆ 85% - 94%: moderate confidence in MCP compliance
- ◆ 75% - 84%: low confidence in MCP compliance
- ◆ <75%: no confidence in MCP compliance

Non-duplication Deeming. CMS permits the opportunity for states to use information from a private accreditation review, such as an NCQA audit, to meet comparable federal regulations. Using results from a comparable audit allows an opportunity for non-duplication deeming.

Non-duplication, as described in EQR protocols, is intended to reduce the administrative burden on the MCPs. When NCQA standards are comparable to federal regulations, and the MCP scored 100% on the applicable NCQA standards, there is an opportunity to “deem,” or consider, the federal regulation as meeting requirements. This process eliminates the need to review the regulation as part of the OSR, thus reducing the administrative burden on the MCP.

DHCF permitted deeming for the 2024 OSR. To qualify for deeming, DHCF established the following criteria:

- The MCP must hold NCQA Health Plan Accreditation.
- The MCP must demonstrate full compliance in the applicable federal regulation for the last two OSR cycles.
- The MCP must provide evidence of the most recent NCQA audit, which includes a fully compliant assessment in the applicable standards for which deeming is being considered.

Using this information and the *NCQA Medicaid Managed Care Toolkit: Standards Crosswalk, 2023 Health Plan Standards (Effective July 1, 2023 – June 30, 2024)*, Qlarant evaluated whether the MCP qualified for deeming of federal regulations in the following standards: Information Requirements, MCO, Quality Assessment and Performance Improvement Program, and the Grievance and Appeal System.

ACDC, HSCSN, and MFC qualified for select deeming in the 2024 OSR. AGP did not qualify for deeming as its NCQA accreditation was limited to an “Interim” status. UHC did not qualify for deeming as the 2024 OSR serves as the MCP’s second comprehensive review.

Deemed elements and components were assessed as met and received one point each.

Results

Table 32 displays the 2024 MCP OSR results by standard and total. DCHFP and CASSIP results reflect MY 2024 performance. DDCP results reflect MY 2023 performance. A level of confidence in each MCP’s compliance is assigned based on the overall weighted score. The table also includes MCP averages.

Table 32. 2024 MCP OSR Results

2024 OSR	ACDC	AGP	HSCSN	MFC	UHC	MCP Average
§438.10 Information Requirements	100.00% ^D	100.00%	100.00% ^D	100.00% ^D	96.67%	99.33%
§438.56 Disenrollment Requirements and Limitations	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
§438.100 - §438.114 Enrollee Rights and Protections	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
§438.206 - §438.242 MCO Standards (See Table 33 for additional detail)	99.12% ^D	98.25%	99.12% ^D	99.12% ^D	100.00%	99.15%
§438.330 Quality Assessment and Performance Improvement Program	100.00% ^D	100.00%	100.00% ^D	100.00% ^D	100.00%	100.00%
§438.402 - §438.424 Grievance and Appeal System	99.11% ^D	98.21%	89.29% ^D	100.00% ^D	95.61%	96.44%
Special Needs Plan*	NA	NA	NA	NA	100.00%	NA
Overall Weighted Score	99.44%	98.89%	96.41%	99.72%	98.42%	98.58%
Confidence Level	High 	High 	High 	High 	High 	High 

DCHFP and CASSIP results reflect MY 2024 performance (site review conducted in October 2024). DDCP results reflect MY 2023 performance (site review conducted in May 2024).

D – Some elements/components in the standard qualified for deeming for the MCP.

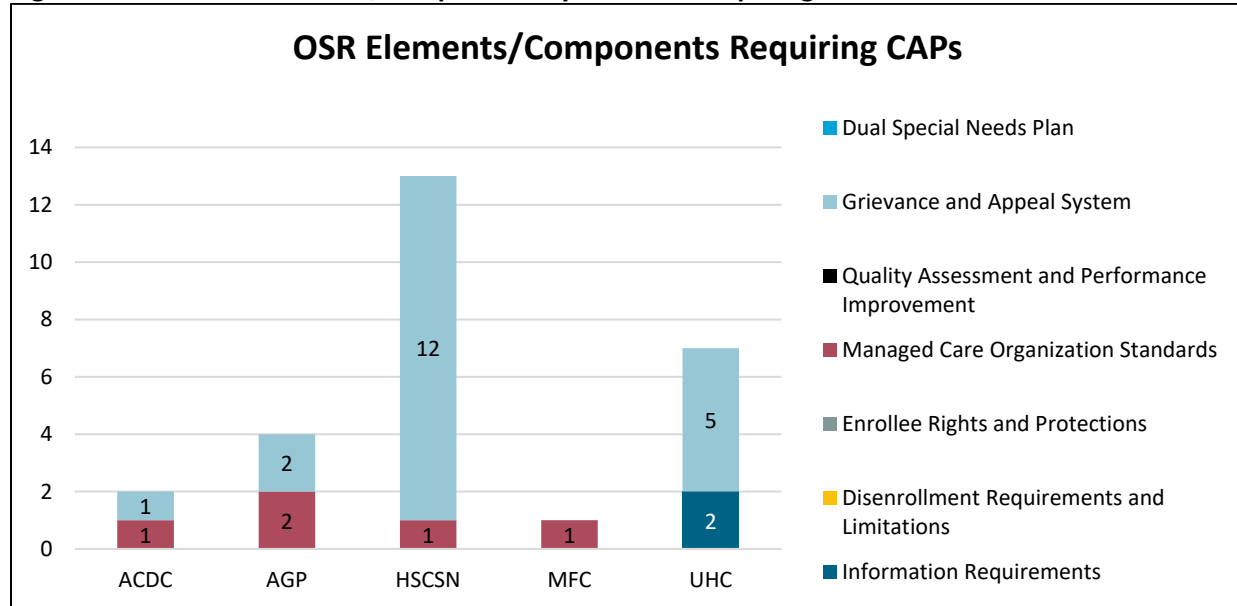
* The Special Needs Plan standard applies to UHC only.

NA – Not Applicable. The standard was not reviewed or not applicable to the MCP.

Rating/Level of confidence scale: High Confidence - 95% to 100%; Moderate Confidence - 85% to 94%; Low Confidence - 75% to 84%, No Confidence - <75%.

MCPs are expected to demonstrate 100 percent compliance with all OSR standards. MCPs demonstrating less than 100 percent must develop a corrective action plan (CAP) to address each element or component not meeting full compliance. Figure 10 illustrates MCP CAPs required by standard.

Figure 10. MCP OSR Elements/Components by Standard Requiring CAPs



All MCPs are required to develop CAPs. The number of CAPs per MCP ranged from 1-13. Most frequently, MCPs are required to develop a Grievance and Appeal System CAP.

Table 33 details MCP results of the MCO Standards (§438.206-§438.242) from the 2024 OSR. Performance, for each area of review, is reported as met, partially met, or not met.

- **Met.** All elements and components for the standard were fully met.
- **Partially Met.** At least one element or component within the standard was not met.
- **Not Met.** None of the elements and components for the standard were met.

Table 33. 2024 MCP OSR Results for MCO Standards - §438.206-§438.242

MCO Standards	ACDC	AGP	HSCSN	MFC	UHC
§438.206 Availability of Services	Met	Met	Met	Met	Met
§438.207 Assurances of Adequate Capacity and Services	Partially Met	Partially Met	Partially Met	Partially Met	Met
§438.208 Coordination and Continuity of Care	Met	Met	Met	Met	Met
§438.210 Coverage and Authorization of Services	Met	Met	Met	Met	Met
§438.214 Provider Selection	Met	Partially Met	Met	Met	Met
§438.224 Confidentiality	Met	Met	Met	Met	Met
§438.228 Grievance and Appeal Systems	Standard reviewed under §438.402 - §438.424 Grievance and Appeal System. See Table 32 for results.				
§438.230 Subcontractual Relationships and Delegation	Met	Met	Met	Met	Met
§438.236 Practice Guidelines	Met	Met	Met	Met	Met
§438.242 Health Information Systems*	Met	Met	Met	Met	Met

DCHFP and CASSIP results reflect MY 2024 performance (site review conducted in October 2024). DDCP results reflect MY 2023 performance (site review conducted in May 2024).

*MCP Health Information Systems were evaluated as part of the PMV activity.

Table 34 details annual MCP results and MCP averages, by standard, for MYs 2022-2024. Individual MCP results are rounded.

Table 34. 2022-2024 MCP OSR Results by Standard

OSR Standards	Year	ACDC	AGP	HSCSN	MFC	UHC	MCP Average
Information Requirements	2022	98%	NA	100%	100%	100%	99.67%
	2023	100%	100%	100%	100%	100%	100.00%
	2024	100%	100%	100%	100%	97%	99.33%
Disenrollment Requirements and Limitations	2022	100%	NA	100%	100%	96%	99.15%
	2023	100%	63%	100%	100%	100%	92.37%
	2024	100%	100%	100%	100%	100%	100.00%
Enrollee Rights and Protections	2022	100%	NA	100%	97%	97%	98.88%
	2023	100%	100%	100%	97%	78%	95.51%
	2024	100%	100%	100%	100%	100%	100.00%
MCO Standards	2022	100%	NA	100%	99%	99%	99.64%
	2023	100%	98%	100%	99%	99%	99.32%
	2024	99%	98%	99%	99%	100%	99.15%
Quality Assessment and Performance Improvement Program	2022	100%	NA	100%	93%	100%	98.61%
	2023	100%	100%	100%	100%	100%	100.00%
	2024	100%	100%	100%	100%	100%	100.00%
Grievance and Appeal System	2022	97%	NA	95%	96%	93%	96.09%
	2023	99%	88%	93%	99%	96%	95.20%
	2024	99%	98%	89%	100%	96%	96.44%
Special Needs Plan	2022	NA	NA	NA	NA	100%	100.00%
	2023	NA	NA	NA	NA	99%	98.57%
	2024	NA	NA	NA	NA	100%	100.00%

OSR Standards	Year	ACDC	AGP	HSCSN	MFC	UHC	MCP Average
Overall Weighted Score	2022	99%	NA	98%	98%	97%	98.45%
	2023	100%^	93%	98%	99%	97%	97.41%
	2024	99%	99%	96%	100%^	98%	98.58%

NA - Not Applicable. No score is available as the standard was not applicable or the MCP was not reviewed.

^ Overall MCP weighted score is 99.72%, rounded to 100%.

Conclusion

Aggregate summary conclusions for the OSR activity are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 60-64, within the [MCP Quality, Access, Timeliness Assessment](#) section.

- The MCPs received overall weighted scores ranging from 96% (HSCSN) to 100% (rounded for MFC) for the 2024 OSR, which evaluated MY 2024 for the DCHFP and CASSIP programs and MY 2023 for the DDCP. The MCP average was 99 percent (high confidence).
- The MCPs had systems, policies, and staff in place to support the core processes and operations necessary to deliver services to its Medicaid enrollees. MCP specific strengths, weaknesses, and recommendations are detailed in the [MCP Quality, Access, Timeliness Assessment](#) section.
- All MCPs have at least one CAP required. Most CAPs are due to noncompliance with the Grievance and Appeal System Standard.
- Follow up on previous annual CAPs are detailed in the [Assessment of Previous Recommendations](#) section.

Network Adequacy Validation

Objective

MCPs must meet specific network adequacy standards established by DHCF. For the District, these standards include provider capacity and geographic accessibility to ensure enrollees have access to an adequate number of providers and may access them in a timely manner. MCPs must report their compliance with DHCF's network adequacy standards on a quarterly basis. NAV activities evaluate MCP data and methods used to calculate compliance with standards. NAV results provide DHCF and other stakeholders a level of confidence in provider network adequacy results reported by the MCPs.

Methodology

This was the first time the NAV activity was conducted in accordance with the *Centers for Medicare and Medicaid Services (CMS) EQR Protocol 4, Validation of Network Adequacy*.¹³ This assessment, conducted in 2024, serves as baseline.

Tables 35-36 include the District's network capacity and geographic accessibility standards that the MCPs are required to calculate and report to DHCF. Table 35 includes network access standards for DCHFP and CASSIP.

¹³ [CMS EQR Protocols](#)

Table 35. DCHFP and CASSIP Network Access Standards

Provider Type	Standard
Network Capacity Standards	
Adult Primary Care Providers (PCPs)	Access to at least one (1) full-time equivalent (FTE) PCP for every 500 enrollees
Pediatric PCPs	Access to at least one (1) FTE PCP with pediatric training for every 500 children and adolescents less than 21 years of age
Dental Providers	Access to at least one (1) FTE dentist for every 750 enrollees
Pediatric Dental Providers	Access to at least one (1) FTE dentist for every 750 children and adolescents less than 21 years of age
Geographic Accessibility Standards	
Behavioral Health— Coordination and Case Management Service, Developmental/Behavioral Health, Inpatient Psychiatric Units (Adult and Pediatric), Partial Hospitalization and Intensive Outpatient Programs, Psychiatrist (Adult and Pediatric), Psychologist (Adult and Pediatric), Residential Treatment Facility, Social Worker	Access to at least one behavioral health provider type within five (5) miles or 30 minutes travel time
Hospital	Access to at least one hospital within five (5) miles or 30 minutes travel time
Laboratory	Access to at least one laboratory within five (5) miles or 30 minutes travel time
Obstetric/Gynecological Care (OB/GYN)	Female enrollee access to at least one OB/GYN provider within five (5) miles or 30 minutes travel time
Primary Care— PCPs may include Family Practice, General Practice, Internal Medicine, Nurse Practitioners	Access to at least two (2) age appropriate PCPs within five (5) miles or 30 minutes travel time
Pharmacy	Access to at least two (2) pharmacies within two (2) miles of each enrollee's residence
Specialty Care— Allergist and Immunologist, Cardiologist, Dermatologist, Endocrinologist, Gastroenterologist (Pediatric and Adult), Geneticist, Inpatient Specialty Facility, Neonatologist, Nephrologist, Neurologist, Neurosurgeon, Oncologist/Hematologist, Ophthalmologist, Orthopedic Surgeon, Otolaryngologist, Perinatologist, Podiatrist, Pulmonary Specialist, Rehabilitation Provider, Rheumatologist, Surgeon, Urologist	Access to at least one specialty care provider within five (5) miles or 30 minutes travel time

Table 36 includes network access standards for the DDCP.

Table 36. DDCP Network Access Standards

Provider Type	Standard
Network Capacity Standards	
Dental Providers	Enrollee access to at least one (1) full-time equivalent (FTE) dentist for every 750 enrollees
Long-Term Service and Supports (LTSS)— Adult Day Health Program Assisted Living Facility Chore/Homemaker Agency Home Health Agency Medical Alert Devices and Services Nursing Facility	Contract with at least three providers for each LTSS type, except Medical Alert Devices and Services requires at least two providers
Primary Care Providers (PCPs)	Enrollee access to at least one (1) FTE PCP for every 500 enrollees
Geographic Accessibility Standards	
Behavioral Health— Coordination and Case Management Service, Developmental Delay Specialists, Behavioral Health Medicine, Inpatient Psychiatric Units, Partial Hospitalization and Intensive Outpatient Programs, Psychiatrist, Psychologist, Residential Treatment Facility, Social Worker	Access to at least one provider within 30 minutes travel time via public transportation
Hospital	Access to at least one hospital within 30 minutes travel time via public transportation
Laboratory	Access to at least one laboratory within five (5) miles or 30 minutes travel time
LTSS— Adult Day Health Program Assisted Living Facility Nursing Facility	Access to Adult Day Health Program providers within 30 minutes travel time by public transportation and access to Assisted Living Facility and Nursing Facility providers within 60 minutes travel time by public transportation
Obstetric/Gynecological Care (OB/GYN)	Female enrollee access to at least one OB/GYN provider within five (5) miles or 30 minutes travel time
Primary Care— PCPs may include Family Practice Physician, General Practice Physician, Internal Medicine Physician, OB/GYN (when appropriate to the enrollee), Osteopath, Clinic or Federally Qualified Health Center, Nurse Practitioner, or a Subspecialty Physician (when appropriate due to an enrollee's special health care needs)	Access to at least two (2) age appropriate PCPs within five (5) miles or 30 minutes travel time
Pharmacy	Access to at least two (2) pharmacies within two (2) miles of each enrollee's residence

Provider Type	Standard
Specialty Care— Allergist and Immunologist, Cardiologist, Dermatologist, Endocrinologist, Gastroenterologist Geneticist, Inpatient Specialty Facility, Nephrologist, Neurologist, Neurosurgeon, Oncologist/Hematologist, Ophthalmologist, Orthopedic Surgeon, Otolaryngologist, Podiatrist, Pulmonary Specialist, Rehabilitation Provider, Rheumatologist, Surgeon, Urologist	Access to at least one specialty care provider within five (5) miles or 30 minutes travel time

Each MCP is required to monitor and report compliance with DHCF-established standards on a quarterly basis using GeoAccess (or similar) software. The MCP uses the most recent enrollee and provider data to geocode each enrollee residence and provider street address, respectively. The software program calculates compliance based on the established standards.

Description of Data Obtained. Qlarant obtained each MCP's Quarter 4 2023 Provider Network Report for use in validation activities in January 2024.¹⁴ MCPs prepared their reports using Quest Analytics software and their Quarter 4 2023 beneficiary enrollment and provider network data files. Qlarant additionally obtained provider, enrollee, mapping, and Information Systems Capabilities Assessment (ISCA) documentation and files. Data and information were also obtained from MCPs during their ISCA interview session, conducted in May 2024.

Technical Methods of Data Collection and Analysis. Using all data sources named above, Qlarant:

- Validated the data and methods used by the MCP to assess network adequacy
- Validated results and generated a validation rating for each indicator
- Reported findings to DHCF

To complete the validation and reporting activities, Qlarant completed worksheets included in the CMS EQR Protocol 4, Validation of Network Adequacy. These worksheets include:

- Worksheet 4.1. State Network Adequacy Standards to be Validated
- Worksheet 4.2. Network Adequacy Indicators to be Validate
- Worksheet 4.3. Data Sources for Network Adequacy Validation
- Worksheet 4.4. Network Adequacy Data Concerns Identified in Review of ISCA
- Worksheet 4.5. Assessment of Network Adequacy Data Sources not Reviewed in the ISCA
- Worksheet 4.6. Assessment of MCP Network Adequacy Data, Methods, and Results
- Worksheet 4.7. Summary of Network Adequacy Validation Findings
- Worksheet 4.8. Recommendations to Improve MCP Assessment of Network Adequacy

Each indicator evaluated was scored based upon a compilation of the worksheet findings, including the MCP's data collection procedures, network adequacy calculation methods, and network adequacy results. The NAV activity does not include an evaluation of the MCP's level of compliance in meeting the

¹⁴ Each MCP's Provider Network Report included minor variances in network adequacy indicators compared to the standards identified in the MCP contract with DHCF. Qlarant accepted these variances as long as they are reasonable and met the intent of DHCF's monitoring and reporting requirements.

District's standards. Instead it evaluates the level of confidence stakeholders can have in the MCP reported result for each indicator. MCP compliance with the network adequacy standards are reported in the OSR (Assurances of Adequate Capacity and Services) and Network Adequacy Survey Focus Study results.

Based on the total score for each network adequacy indicator, Qlarant assigned a validation rating. The validation rating refers to Qlarant's overall confidence that the MCP used acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator. The validation scores and ratings are described below.

- ❖ 90.0% - 100%: **high confidence** in MCP methods and results
- ❖ 50.0% - 89.9%: **moderate confidence** in MCP methods and results
- ❖ 10.0% - 49.9%: **low confidence** in MCP methods and results
- ❖ <10.0%: **no confidence** in MCP methods and results

Results

Each MCP's Provider Network Report included minor variances in network adequacy indicators compared to the standards identified in the MCP contract with DHCF. For example, some MCPs combined PCP-type providers, while other MCPs separated each type of PCP in their reporting. Qlarant accepted these variances as long as they were reasonable and met the intent of DHCF's monitoring and reporting requirements. As a result of the variances, the number of indicators that were audited for each MCP vary.

For this first year of study, MCPs were not penalized for missing, or omitted, indicators. Instead, DHCF quickly addressed the missing indicators with each MCP and required MCPs to include missing indicators in the next quarterly report submission. In future NAV activities, MCPs will receive a "no confidence" rating for each missing indicator.

DCHFP and CASSIP Results

Tables 37-38 include network capacity indicator validation results for DCHFP and CASSIP MCPs. Each validated indicator received a score of high, moderate, low, or no confidence. The number of missing indicators is identified in red font.

Table 37. 2024 DCHFP and CASSIP Network Capacity Indicator Validation Results

Network Capacity Indicator Validation	ACDC	AGP	HSCSN	MFC
Dental Providers				
Total Number of Indicators Validated	2	1	1	2
High Confidence Indicators	2	1	1	2
Moderate Confidence Indicators	0	0	0	0
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	0	1	1	0
Primary Care Providers				
Total Number of Indicators Validated	2	2	2	2
High Confidence Indicators	2	2	2	2
Moderate Confidence Indicators	0	0	0	0
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	0	0	0	0

*Missing indicators were not scored during this first validation cycle. MCPs were notified of missing indicators and informed they will be scored in the next annual review.

Rating/Level of confidence scale: High Confidence - 90.0% to 100%; Moderate Confidence - 50.0% to 89.9%; Low Confidence - 10.0% to 49.9%, No Confidence - <10.0%.

Table 38. 2024 DCHFP and CASSIP Geographic Accessibility Indicator Validation Results

Geographic Accessibility Indicator Validation	ACDC	AGP	HSCSN	MFC
Behavioral Health Providers				
Total Number of Indicators Validated	11	12	2	1
High Confidence Indicators	11	12	2	1
Moderate Confidence Indicators	0	0	0	0
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	1	2	11	11
Hospital				
Total Number of Indicators Validated	1	1	1	1
High Confidence Indicators	1	1	1	1
Moderate Confidence Indicators	0	0	0	0
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	0	0	0	0
Laboratory				
Total Number of Indicators Validated	1	0	1	1
High Confidence Indicators	1	0	1	1
Moderate Confidence Indicators	0	0	0	0
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	0	1	0	0
Obstetric/Gynecological Care Providers				
Total Number of Indicators Validated	1	1	1	1
High Confidence Indicators	1	1	1	1

Geographic Accessibility Indicator Validation	ACDC	AGP	HSCSN	MFC
Moderate Confidence Indicators	0	0	0	0
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	0	0	0	0
Primary Care Providers				
Total Number of Indicators Validated	6	3	4	2
High Confidence Indicators	6	3	4	2
Moderate Confidence Indicators	0	0	0	0
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	0	0	0	0
Pharmacies				
Total Number of Indicators Validated	0	1	1	1
High Confidence Indicators	0	1	1	0
Moderate Confidence Indicators	0	0	0	1
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	1	0	0	0
Specialty Care Providers				
Total Number of Indicators Validated	22	27	22	31
High Confidence Indicators	22	27	22	31
Moderate Confidence Indicators	0	0	0	0
Low Confidence Indicators	0	0	0	0
No Confidence Indicators	0	0	0	0
Missing Indicators*	1	0	5	2

*Missing indicators were not scored during this first validation cycle. MCPs were notified of missing indicators and informed they will be scored in the next annual review.

Rating/Level of confidence scale: High Confidence - 90.0% to 100%; Moderate Confidence - 50.0% to 89.9%; Low Confidence - 10.0% to 49.9%, No Confidence - <10.0%.

ACDC achieved a high confidence rating for each network adequacy indicator reported in their Provider Network Report. However, ACDC failed to report geographic accessibility indicators for the following provider types:

- Social Workers
- Pharmacies
- Surgeons

AGP achieved a high confidence rating for each network adequacy indicator reported in their Provider Network Report. However, AGP failed to report the network capacity indicator for the following provider type:

- Dental Providers (pediatric)

Additionally, AGP failed to report geographic accessibility indicators for the following provider types:

- Coordination and Case Management Services
- Partial Hospitalization and Intensive Outpatient Programs
- Laboratory Providers

HSCSN achieved a high confidence rating for each network adequacy indicator reported in their Provider Network Report. However, HSCSN failed to report the network capacity indicator for the following provider type:

- Dental Providers (pediatric)

Additionally, HSCSN failed to report geographic accessibility indicators for the following provider types:

- Coordination and Case Management Services
- Developmental/Behavioral Health Programs
- Inpatient Psychiatric Facilities (adult)
- Inpatient Psychiatric Facilities (pediatric)
- Partial Hospitalization and Intensive Outpatient Programs
- Psychiatrist (adult)
- Psychiatrist (pediatric)
- Psychologist (adult)
- Psychologist (pediatric)
- Residential Treatment Facilities
- Social Workers
- Dermatologists
- Gastroenterologist (adult)
- Gastroenterologist (pediatric)
- Inpatient Specialty Facilities
- Rehabilitation Providers

MFC achieved a high confidence rating for each network adequacy indicator reported in their Provider Network Report, with one exception; the MCP received a moderate confidence rating for its pharmacy indicator that measures geographic accessibility for enrollees. The MCP completed its calculation based upon access to one or more pharmacies, rather than two or more pharmacies. Additionally, MFC failed to report geographic accessibility indicators for the following provider types:

- Coordination and Case Management Services
- Developmental/Behavioral Health Programs
- Inpatient Psychiatric Facilities (adult)
- Inpatient Psychiatric Facilities (pediatric)
- Partial Hospitalization and Intensive Outpatient Programs
- Psychiatrist (adult)
- Psychiatrist (pediatric)
- Psychologist (adult)
- Psychologist (pediatric)
- Residential Treatment Facilities
- Social Workers

- Gastroenterologist (adult)
- Inpatient Specialty Facilities

DDCP Results

Tables 39-40 include network capacity indicator validation results for the DDCP MCP. Each validated indicator received a score of high, moderate, low, or no confidence. The number of missing indicators is identified in red font.

Table 39. 2024 DDCP Network Capacity Indicator Validation Results

Network Capacity Indicator Validation	UHC
Dental Providers	
Total Number of Indicators Validated	1
High Confidence Indicators	1
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	0
Long-term Services and Supports	
Total Number of Indicators Validated	4
High Confidence Indicators	4
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	2
Primary Care Providers	
Total Number of Indicators Validated	1
High Confidence Indicators	1
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	0

*Missing indicators were not scored during this first validation cycle. MCPs were notified of missing indicators and informed they will be scored in the next annual review.

Rating/Level of confidence scale: High Confidence - 90.0% to 100%; Moderate Confidence - 50.0% to 89.9%; Low Confidence - 10.0% to 49.9%, No Confidence - <10.0%.

Table 40. 2024 DDCP Geographic Accessibility Indicator Validation Results

Geographic Accessibility Indicator Validation	UHC
Behavioral Health Providers	
Total Number of Indicators Validated	2
High Confidence Indicators	2
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	7
Hospital	
Total Number of Indicators Validated	1
High Confidence Indicators	1

Geographic Accessibility Indicator Validation	UHC
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	0
Laboratory	
Total Number of Indicators Validated	0
High Confidence Indicators	0
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	1
Long-term Services and Supports	
Total Number of Indicators Validated	3
High Confidence Indicators	3
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	0
Obstetric/Gynecological Care	
Total Number of Indicators Validated	1
High Confidence Indicators	1
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	0
Primary Care Providers	
Total Number of Indicators Validated	1
High Confidence Indicators	1
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	0
Pharmacies	
Total Number of Indicators Validated	1
High Confidence Indicators	1
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	0
Specialty Care Providers	
Total Number of Indicators Validated	21
High Confidence Indicators	21
Moderate Confidence Indicators	0
Low Confidence Indicators	0
No Confidence Indicators	0
Missing Indicators*	1

*Missing indicators were not scored during this first validation cycle. MCPs were notified of missing indicators and informed they will be scored in the next annual review.

Rating/Level of confidence scale: High Confidence - 90.0% to 100%; Moderate Confidence - 50.0% to 89.9%; Low Confidence - 10.0% to 49.9%, No Confidence - <10.0%.

UHC achieved a high confidence rating for each network adequacy indicator reported in their Provider Network Report. However, UHC failed to report the network capacity indicators for the following provider types:

- Chore/Homemaker Agencies
- Medical Alert Devices and Services

Additionally, UHC failed to report geographic accessibility indicators for the following provider types:

- Behavioral Health Medicine Providers
- Coordination and Case Management Services
- Developmental Delay Specialists
- Inpatient Psychiatric Facilities
- Partial Hospitalization and Intensive Outpatient Programs
- Residential Treatment Facilities
- Social Workers
- Laboratory Providers
- Inpatient Specialty Facilities

Conclusion

Aggregate summary conclusions for the NAV activities are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 60-64, within the [MCP Quality, Access, Timeliness Assessment](#) section.

- Overall, stakeholders can have high confidence in each MCP's Provider Network Report, which includes network capacity and geographic accessibility indicator compliance with DHCF established provider network standards. This assessment is based upon the evaluation of each MCP's data collection procedures, methods of analysis, and interpretation of results.
- All MCPs received a high compliance rating for each indicator they reported, with one exception: MFC received a moderate confidence rating in their pharmacy measure in regard to geographic accessibility. The MCP completed its calculation based upon access to one or more pharmacies, rather than two or more pharmacies, as required.
- All MCPs failed to include all required indicators:
 - ACDC omitted three indicators.
 - AGP omitted four indicators.
 - HSCSN omitted 17 indicators.
 - MFC omitted 13 indicators.
 - UHC omitted 11 indicators.
- DHCF immediately addressed the missing indicator issue with each MCP and required the reporting of all mandatory indicators in the next Provider Network Report quarterly submission.

Encounter Data Validation

Objective

States rely on valid and reliable encounter data submitted by MCPs to make key decisions. For example, states may use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates. As payment methodologies evolve and incorporate value-based payment elements, collecting complete and accurate encounter data is critical. Results of the EDV study provide DHCF a level of confidence in the completeness and accuracy of electronic encounter data submitted by the MCPs.

Methodology

Qlarant's 2024 EDV activities focused on an evaluation of provider office encounters occurring between July 1, 2022 and June 30, 2023 for the DCHFP and CASSIP MCPs.

Description of Data Obtained. Qlarant obtained the following data to complete the EDV study:

- Electronic encounter data file received from DHCF for the period of review (July 1, 2022 - June 30, 2023)
- Information Systems Capabilities Assessment (ISCA) and HEDIS Roadmap documentation from the MCPs
- Medical records from providers

Technical Methods of Data Collection and Analysis. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*.¹⁵ To assess the completeness and accuracy of MCP encounter data, Qlarant completed the following activities:

- Reviewed DHCF requirements for collecting and submitting encounter data.
- Reviewed each MCP's capability to produce accurate and complete encounter data, which included an evaluation of the MCP's ISCA, HEDIS Roadmap, and interviews with key MCP staff.
- Reviewed medical records to confirm electronic encounter data accuracy.

Only valid medical records were reviewed for the study. Medical records were assessed as valid if they were legible and the patient demographic information submitted in the medical record matched information in the encounter data file.

To complete the medical record reviews, Qlarant reviewers compared medical record documentation to electronic encounter data to confirm the accuracy of reported encounters. Specifically, reviewers evaluated the accuracy of diagnosis and procedure codes for the randomly selected encounters. All diagnosis and procedure codes associated with an encounter were reviewed. When documentation supported the diagnosis and procedure codes for the encounter under review, results were assessed as matching. When documentation did not support the diagnosis or procedure codes, results were assessed as not matching (or deemed as "no match").

¹⁵ [CMS EQR Protocols](#)

Validation results include a score and level of confidence for the diagnosis code match rate, procedure code match rate, and overall match rate. The validation scores and ratings are described below.

- ◆ 95.0% - 100%: **high confidence** in MCP encounter data
- ◆ 85.0% - 94.9%: **moderate confidence** in MCP encounter data
- ◆ 75.0% - 84.9%: **low confidence** in MCP encounter data
- ◆ <75.0%: **no confidence** in MCP encounter data

This EQR activity was completed for the DCHFP and CASSIP MCPs. The DDCP D-SNP was not required to participate in the EDV study.

Due to AGP's contract start date of April 1, 2023, AGP's results are based on encounters that occurred from April 1, 2023 through June 30, 2023.

Results

Qlarant found all MCPs had the capability to produce accurate and complete encounter data. Conclusions were drawn based on reviews of ISCA and Roadmap evaluations, interviews with MCP personnel critical to processes, and demonstrations of Information System processes. Table 41 indicates each MCP was found capable of producing accurate and complete encounter data, based on auditing activities completed in 2024.

Table 41. MCP Capability of Producing Accurate and Complete Encounter Data

2024 EDV	ACDC	AGP	HSCSN	MFC
Capable of producing accurate and complete encounter data	◆	◆	◆	◆

◆ The MCP is capable of producing accurate and complete encounter data, as required by DHCF.

Qlarant's medical record review evaluated the accuracy of diagnosis and procedure codes in the electronic encounter data. Table 42 displays MCP accuracy or "match rates." A match occurs when the electronic diagnosis and procedure codes are supported by medical record documentation. The 2024 medical record reviews, evaluating encounters that occurred between July 1, 2022 and June 30, 2023, confirmed, on average, moderate encounter data accuracy.

Table 42. MCP Encounter Data Accuracy

2024 EDV	ACDC	AGP	HSCSN	MFC	MCP AVG
Accuracy or Match Rate	95.0%	97.6%	90.9%	92.8%	94.5%
Confidence Level	High ◆	High ◆	Moderate ◆	Moderate ◆	Moderate ◆

Rating/Level of confidence scale: High Confidence - 95.0% to 100%; Moderate Confidence - 85.0% to 94.9%; Low Confidence - 75.0% to 84.9%, No Confidence - <75.0%.

The MCP-weighted average was 94.5%, which marginally missed the high encounter data confidence level of 95.0%. Individual MCP performance ranged from 90.9% (HSCSN) to 97.6% (AGP). Tables 43-44 further analyze these results and include diagnosis code and procedure code findings, respectively.

Table 43 includes diagnosis code match rate findings and reasons for "no match."

Table 43. Diagnosis Code Findings

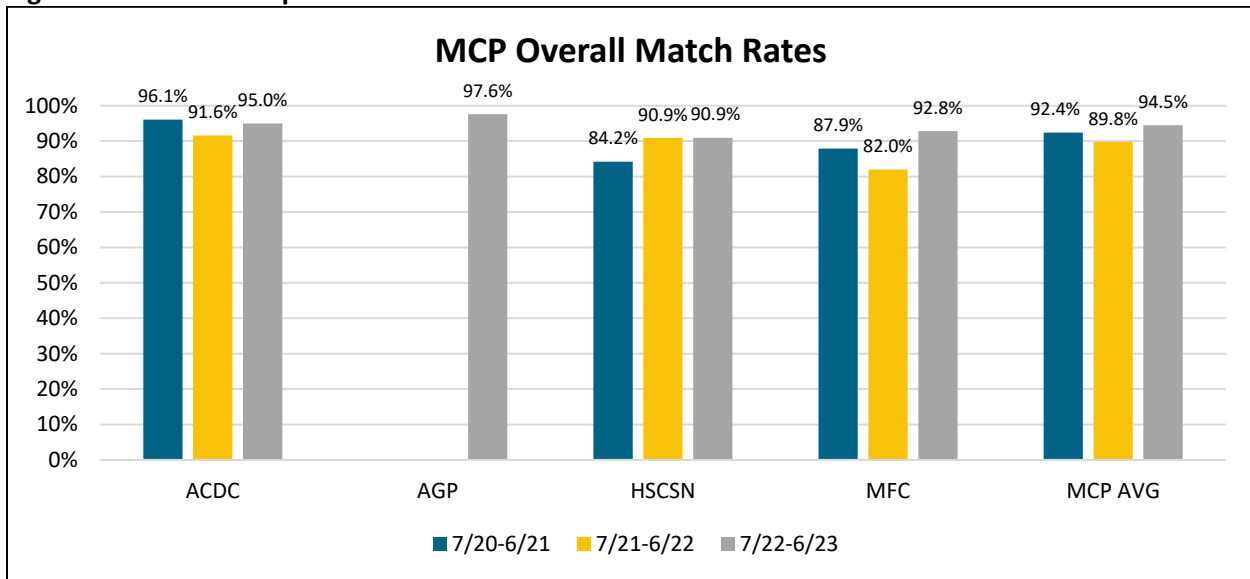
Diagnosis Codes	ACDC	AGP	HSCSN	MFC	MCP Aggregate
Diagnosis Codes with a Match					
Accuracy or Match Rate	97.2%	98.8%	87.1%	93.8%	95.5%
Diagnosis Codes with “No Match”					
“No Match” Rate	2.8%	1.2%	12.9%	6.2%	4.5%
“No Match” Reasons					
Percentage of diagnosis code elements with coding errors	0.1%	0.3%	0.3%	0.0%	0.2%
Percentage of diagnosis code elements that were not supported by medical record documentation	2.7%	1.0%	12.6%	6.2%	4.3%

Table 44 includes procedure code match rate findings and reasons for “no match.”

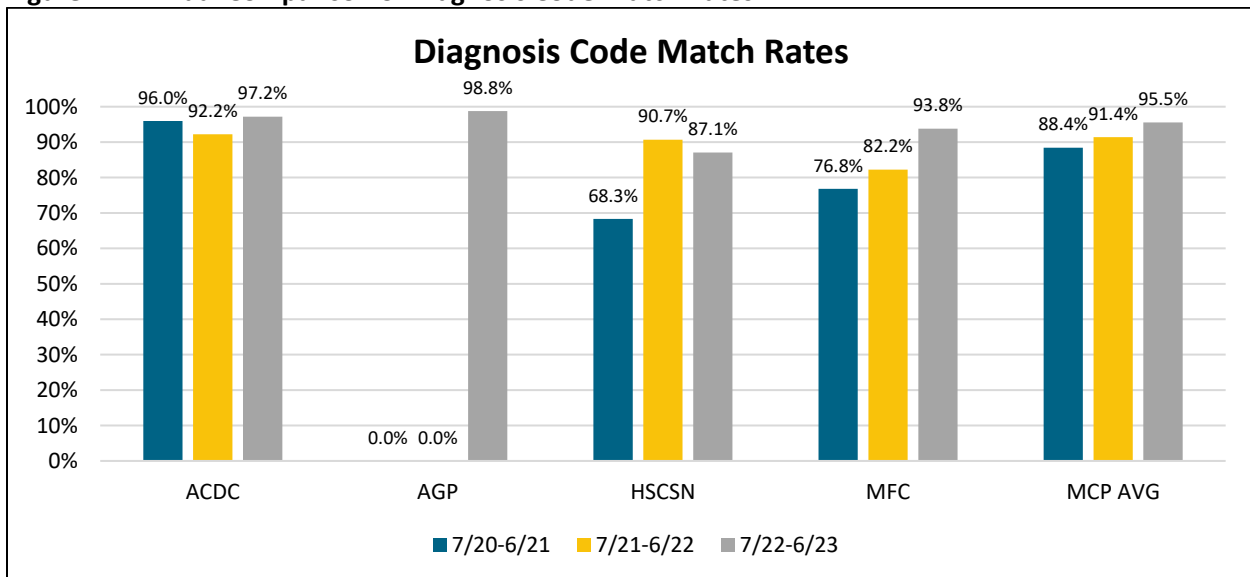
Table 44. Procedure Code Findings

Procedure Codes	ACDC	AGP	HSCSN	MFC	MCP Aggregate
Procedure Codes with a Match					
Accuracy or Match Rate	90.6%	95.0%	94.6%	91.0%	92.6%
Procedure Codes with “No Match”					
“No Match” Rate	9.4%	5.0%	5.4%	9.0%	7.4%
“No Match” Reasons					
Percentage of procedure code elements with coding errors	3.7%	4.7%	2.0%	3.7%	3.6%
Percentage of procedure code elements that were not supported by medical record documentation	5.8%	0.3%	3.4%	5.3%	3.8%

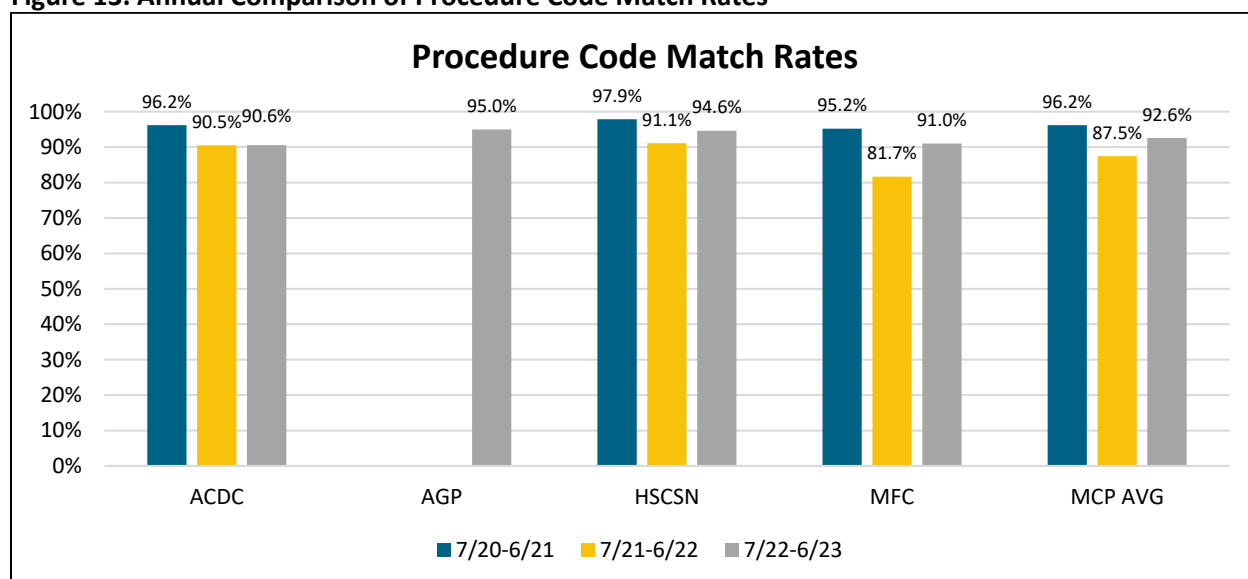
Figures 11-13 illustrate annual comparisons in overall, diagnosis, and procedure code match rates per MCP and on average.

Figure 11. Annual Comparison of Overall Match Rates

AGP's contract commenced April 1, 2023; therefore no results are available for the first two annual assessments.

Figure 12. Annual Comparison of Diagnosis Code Match Rates

AGP's contract commenced April 1, 2023; therefore no results are available for the first two annual assessments.

Figure 13. Annual Comparison of Procedure Code Match Rates

AGP's contract commenced April 1, 2023; therefore no results are available for the first two annual assessments.

Conclusion

Aggregate summary conclusions for the EDV activity are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 60-64 within the [MCP Quality, Access, Timeliness Assessment](#) section.

- An evaluation of each MCP's ISCA determined all MCPs had the capability to produce accurate and complete encounter data for the period under review.
- A medical record review determined an overall encounter data accuracy of 94.5% (DC Average); this is a 4.7 percentage point improvement in performance compared to previous annual performance.
- A match rate analysis at the diagnosis and procedure code level concluded an MCP average of 95.5% and 92.6%, respectively.
- Most "no match" findings were due to lack of documentation in the medical record.

Network Adequacy Survey Focus Study

Objective

MCPs must develop and maintain adequate provider networks to ensure timely access to care and services. The Network Adequacy Survey Focus Study evaluates whether MCPs are meeting standards established by DHCF. Focus study results provide DHCF and other stakeholders a level of confidence in provider network adequacy.

Methodology

Qlarant conducted a comprehensive assessment of each MCP's provider network available to enrollees in each DCHFP, CASSIP, and DDCP, as applicable, during MY 2024. This was the second annual assessment conducted for the DDCP D-SNP provider network.

DCHFP and CASSIP Methodology

Activities conducted as part of the 2024 annual Network Adequacy Survey Focus Study for the DCHFP and CASSIP MCPs include:

- Assessment of MCP provider network geographic access and provider-to-enrollee ratios.
- Validation of the accuracy of MCP online provider directories.
- Assessment of enrollee access to timely provider appointments.

Description of Data Obtained. Qlarant used findings from the MCPs' Provider Network Reports, which were validated as part of the 2024 NAV activity. The reports conveyed MCP compliance with DHCF time and distance standards, as well as provider-to-enrollee ratios. Additionally, Qlarant obtained current provider directory information from the MCPs for use in the provider survey and validation activities.

Provider directory files included the following adult and pediatric PCP information: provider name, credentials, national provider identifier, provider type, specialty, practice name, address, and telephone number.

- Adult PCPs were defined as providers offering appointments for routine primary care services, such as physicals and sick visits, to any enrollee 21 years of age or older. Specialties included family medicine, internal medicine, adult medicine, general medicine, family nurse practitioner, or geriatrics.
- Pediatric PCPs were defined as providers offering appointments for routine primary care services, such as physicals and sick visits, to any enrollee 20 years of age or younger. Specialties included family medicine, pediatrics, adolescent medicine, general medicine, or family nurse practitioner.

Technical Methods of Data Collection and Analysis. Qlarant compared validated MCP Provider Network Report statistics to provider network time, distance, and provider-to-enrollee ratio standards; assessed MCP provider access and availability compliance with timely appointment standards; and validated the accuracy of each MCP's online provider directory. An abbreviated summary of MCP provider network standards is provided below.

DCHFP and CASSIP Provider Network Standards

Mileage and travel. Care must be available within 5 miles or no more than 30 minutes travel time (from an enrollee's residence).

Network composition. All enrollees shall have at least 2 age-appropriate PCPs available meeting mileage and travel standards.

Provider-to-enrollee ratios. At least 1 PCP for every 500 enrollees and at least 1 pediatric PCP for every 500 child and adolescent enrollees.

24-hour urgent care appointment. Services must be available 24 hours a day, 7 days a week, when medically necessary.

30-day routine care appointment. Adult enrollees should obtain routine and well health assessments within 30 days. Pediatric enrollees should obtain EPSDT screening examinations within 30 days.

Qlarant randomly selected providers to survey and assess compliance with DHCF-established standards. Surveys were conducted during quarter 4 2024 using Qlarant-developed tools and experienced surveyors following scripts. A maximum of three telephone call attempts were made for each provider during normal business hours, except for the noon hour when offices typically close for lunch. Surveys were considered successful if the surveyor was able to reach the intended provider/practice and complete the survey.

Qlarant completed online provider directory validations using provider directory data obtained from the MCPs and information gathered during the telephone surveys. The online provider directory listing was considered accurate when all of the following criteria were met:

- Provider was with the practice contacted
- Provider offered the desired primary care services
- Provider accepted the listed (participating) MCP insurance
- Provider appeared in the online provider directory
- Response to provider accepting new patients matched the online provider directory
- Practice name matched the online provider directory
- Address matched the online provider directory
- Telephone number matched the online provider directory

DDCP Methodology

Activities conducted as part of the 2024 annual Network Adequacy Survey Focus Study for the DDCP D-SNP include:

- Assessment of D-SNP provider network including minimum numbers of providers and geographic access.
- Validation of the accuracy of D-SNP online provider directory.
- Assessment of enrollee access to timely services.

Description of Data Obtained. Qlarant used findings from the D-SNP's Provider Network Report, which were validated as part of the 2024 NAV activity. The report conveyed D-SNP compliance with DHCF time and distance standards, as well as provider counts for each LTSS provider type. Additionally, Qlarant

obtained current provider directory information from the D-SNP for use in the survey and validation activities.

The provider directory file included the following information: LTSS provider/practice name, credentials, national provider identifier, provider type, specialty, address, and telephone number.

Technical Methods of Data Collection and Analysis. Qlarant compared validated D-SNP Provider Network Report statistics to provider network time/distance standards; assessed D-SNP compliance with network composition standards and timely access; and validated the accuracy of the D-SNP's online provider directory. An abbreviated summary of the DDCP D-SNP's provider network standards is provided below.

DDCP Provider Network Standards

Geographic access. Enrollee travel time (from enrollee residence), via public transportation, should not exceed: 30 minutes to an adult day health program provider, 60 minutes to an assisted living facility provider, and 60 minutes to a nursing facility provider.

Network composition. All enrollees shall have access to no fewer than three assisted living facilities, adult day health program providers, chore/homemaker agencies, home health agencies, and nursing facilities. All enrollees shall have access to no fewer than two medical alert devices/services providers.

Timely access. Home health agency covered services should be initiated within 72 hours of acceptance of a referral.

Qlarant evaluated *all* LTSS providers to gauge compliance with DHCF-established standards. Surveys were conducted during quarter 4 2024 using Qlarant-developed tools and experienced surveyors following scripts. A maximum of three telephone call attempts were made for each provider during normal business hours, except for the noon hour when offices typically close for lunch. Surveys were considered successful if the surveyor was able to reach the intended provider/practice and complete the survey.

Qlarant completed online provider directory validations using provider directory data obtained from the D-SNP and information gathered during the telephone surveys. The online provider directory listing was considered accurate when all of the following criteria were met:

- Provider accepted UHC insurance
- Provider appeared in the online provider directory
- Address, originally provided by the D-SNP or corrected during the telephone survey, matched the online provider directory
- Telephone number, originally provided by the D-SNP or obtained during the telephone survey, matched the online provider directory
- Response to provider accepting new patients matched the online provider directory
- Practice name, originally provided by the D-SNP or corrected during the telephone survey, matched the online provider directory

Results

Provider Network Standards

DCHFP and CASSIP Geographic Access. Table 45 displays MY 2024 results for geographic access for each MCP and the MCP average.

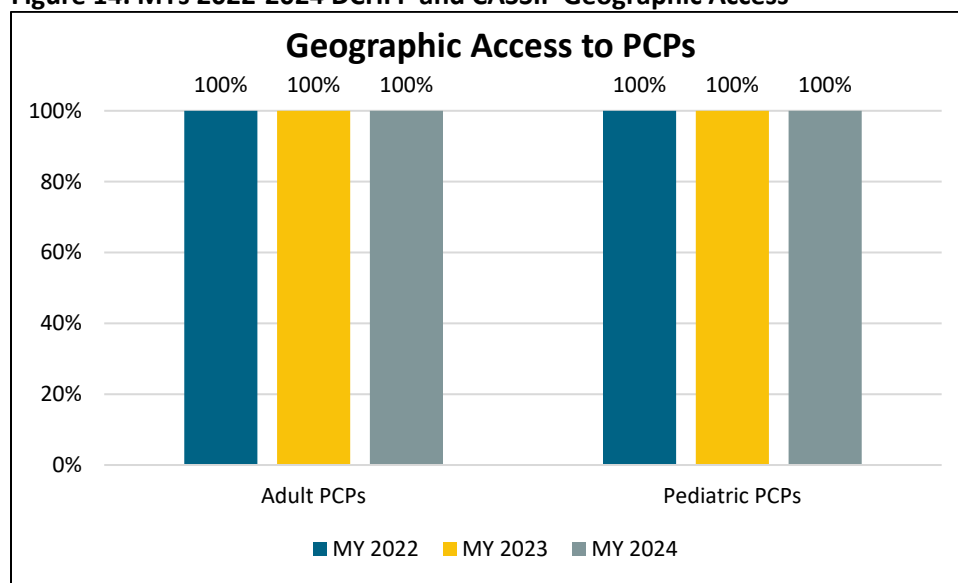
Table 45. MY 2024 DCHFP and CASSIP Geographic Access

2024 Access and Availability	ACDC	AGP	HSCSN	MFC	MCP AVG
Adult PCPs – access at least 2 PCPs within 5 miles or 30 minutes	100%	100%*	100%	100%	100%
Pediatric PCPs – access at least 2 PCPs within 5 miles or 30 minutes	100%	100%*	100%	100%	100%

*AGP's results are rounded from 99.9% to 100%.

All MCPs demonstrated having at least two age-appropriate PCPs within five miles or 30 minutes of enrollees' residences. Figure 14 includes the MCP averages from MYs 2022-2024.

Figure 14. MYs 2022-2024 DCHFP and CASSIP Geographic Access

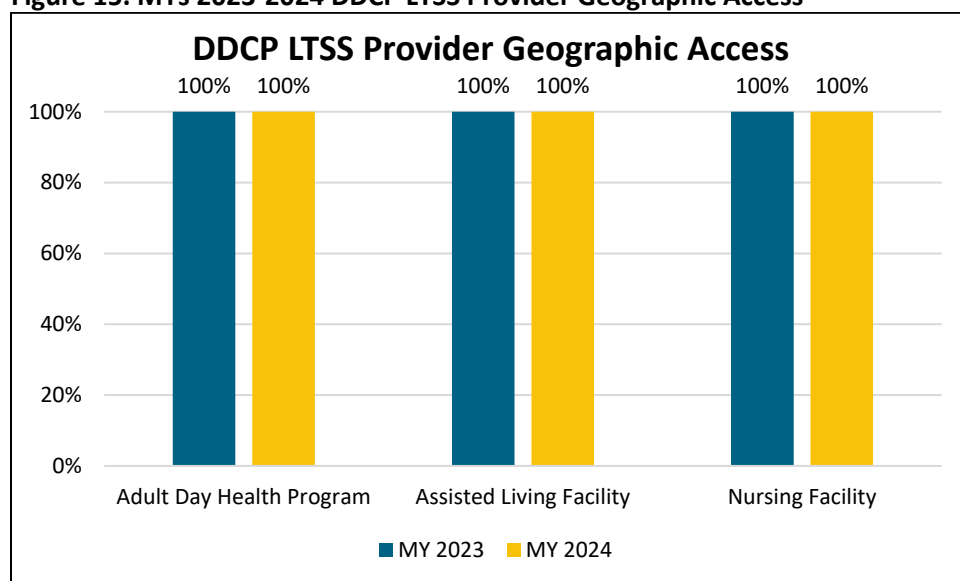


DDCP Geographic Access. Table 46 displays MY 2024 results for geographic access for select UHC LTSS providers, which would require enrollee travel.

Table 46. MY 2024 DDCP LTSS Provider Geographic Access

2024 Access and Availability	UHC
Adult Day Health Program – access within 30 minutes of enrollee travel	100%
Assisted Living Facility – access within 60 minutes of enrollee travel	100%
Nursing Facility – access within 60 minutes of enrollee travel	100%

UHC demonstrated full compliance in meeting the geographic access enrollee travel time standards. Figure 15 includes the DDCP LTSS provider geographic access compliance rates from MYs 2023-2024.

Figure 15. MYs 2023-2024 DDCP LTSS Provider Geographic Access

DCHFP and CASSIP Provider-to-Enrollee Ratios. Table 47 displays MY 2024 compliance results for meeting the provider-to-enrollee ratio requirements for each MCP and the MCP average.

Table 47. MY 2024 DCHFP and CASSIP Provider-to-Enrollee Ratios

2024 Provider-to-Enrollee Ratios	ACDC	AGP	HSCSN	MFC	MCP AVG
Adult PCPs – access to at least 1 PCP for every 500 adult enrollees	1:52 Met	1:173 Met	1:7 Met	1:250 Met	Met
Pediatric PCPs – access to at least 1 PCP for every 500 child and adolescent enrollees	1:46 Met	1:82 Met	1:12 Met	1:38 Met	Met

All MCPs demonstrated having at least one adult PCP for every 500 adult enrollees and at least one pediatric PCP for every 500 child and adolescent enrollees. Table 48 includes the MCP averages from MYs 2022-2024.

Table 48. MYs 2022-2024 DCHFP and CASSIP Provider-to-Enrollee Ratios

Provider-to-Enrollee Ratios	MY	MCP AVG
Adult PCPs – access to at least 1 PCP for every 500 adult enrollees	2022	Met
	2023	Met
	2024	Met
Pediatric PCPs – access to at least 1 PCP for every 500 child and adolescent enrollees	2022	Met
	2023	Met
	2024	Met

DDCP Minimum Number of LTSS Providers. Table 49 displays MY 2024 compliance results for meeting the minimum number of LTSS provider requirements for UHC.

Table 49. MY 2024 DDCP Minimum Number of LTSS Providers

LTSS Provider	Number of Providers		
	Required	Actual	Compliance
Adult Day Health Program	Minimum of 3	6	100%
Assisted Living Facility	Minimum of 3	5	100%
Chore/Homemaker Agency	Minimum of 3	4	100%
Home Health Agency	Minimum of 3	24	100%
Medical Alert Devices and Services Provider	Minimum of 2	3	100%
Nursing Facility	Minimum of 3	18	100%

UHC met the minimum number of LTSS provider requirements. Table 50 displays UHC compliance results for meeting the minimum number of LTSS provider requirements for MYs 2023-2024.

Table 50. MYs 2023-2024 DDCP Minimum Number of LTSS Providers

LTSS Provider	Minimum Number of LTSS Providers Compliance		
	Required	MY 2023	MY 2024
Adult Day Health Program	Minimum of 3	100%	100%
Assisted Living Facility	Minimum of 3	100%	100%
Chore/Homemaker Agency	Minimum of 3	100%	100%
Home Health Agency	Minimum of 3	100%	100%
Medical Alert Devices and Services Provider	Minimum of 2	100%	100%
Nursing Facility	Minimum of 3	100%	100%

Provider Appointment Access and Availability

DCHFP and CASSIP Survey Results. Qlarant surveyed adult and pediatric PCPs during 2024. Table 51 displays results of key provider access and availability measures for each MCP and the MCP average.

Table 51. MY 2024 DCHFP and CASSIP MCP Key Provider Access and Availability Measure Results

2024 Access and Availability	ACDC	AGP	HSCSN	MFC	MCP AVG
Successful contact with provider	63%	47%	57%	57%	56%
Provider is with practice and provides desired services	82%	77%	74%	88%	80%
Provider accepts the listed MCP	90%	80%	85%	92%	87%
Provider appeared in the online provider directory	100%	100%	100%	100%	100%
Provider accepts new patients	100%	98%	100%	97%	99%

Up to three attempts were made to contact each provider. The successful contact average was 56%. Unsuccessful contacts were most frequently due to “Hold Time >5 Minutes” (32%). For the successfully contacted providers, most reported they accepted the identified MCP insurance (87%) and accepted new patients (99%).

Tables 52-53 include MY 2024 adult and pediatric PCP compliance with routine and urgent appointment standards. Appointments were offered via in-person and telehealth. For both adults and children, timely access was better achieved with routine care, compared to urgent care.

Table 52. MY 2024 DCHFP and CASSIP MCP Adult PCP Appointment Compliance

2024 Access and Availability	ACDC	AGP	HSCSN	MFC	MCP AVG
Adult PCP Routine Appointment Compliance	88%	92%	95%	100%	93%
Adult PCP Urgent Appointment Compliance	92%	88%	85%	81%	87%

Table 53. MY 2024 DCHFP and CASSIP MCP Pediatric PCP Appointment Compliance

2024 Access and Availability	ACDC	AGP	HSCSN	MFC	MCP AVG
Pediatric PCP Routine Appointment Compliance	100%	100%	96%	92%	97%
Pediatric PCP Urgent Appointment Compliance	88%	95%	92%	77%	88%

Figures 16-17 include the MCP averages from MYs 2022-2024. Positive trends in appointment compliance with PCPs are noted in adult routine and urgent appointments and pediatric routine appointments. While no trend was noted in pediatric urgent appointments, a 14 percentage point improvement occurred over this last year.

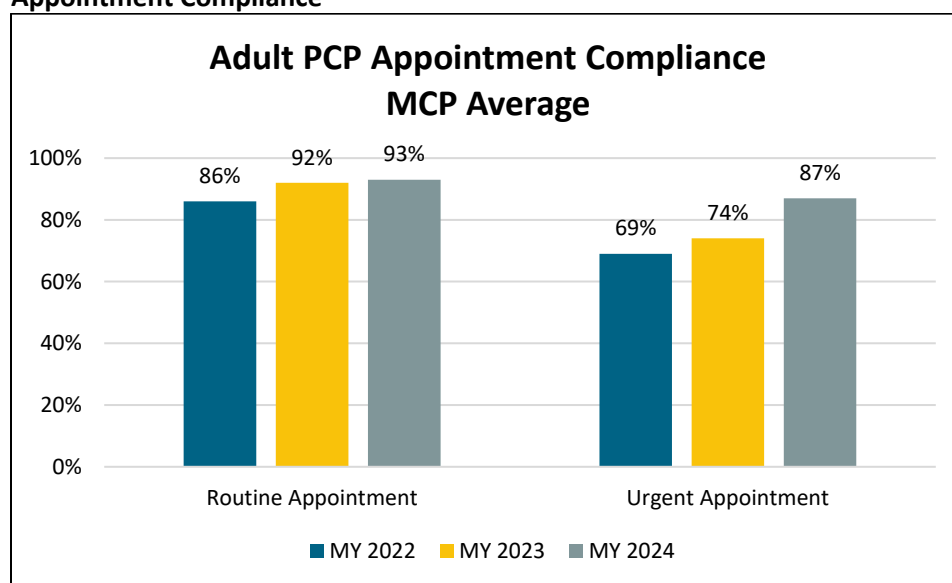
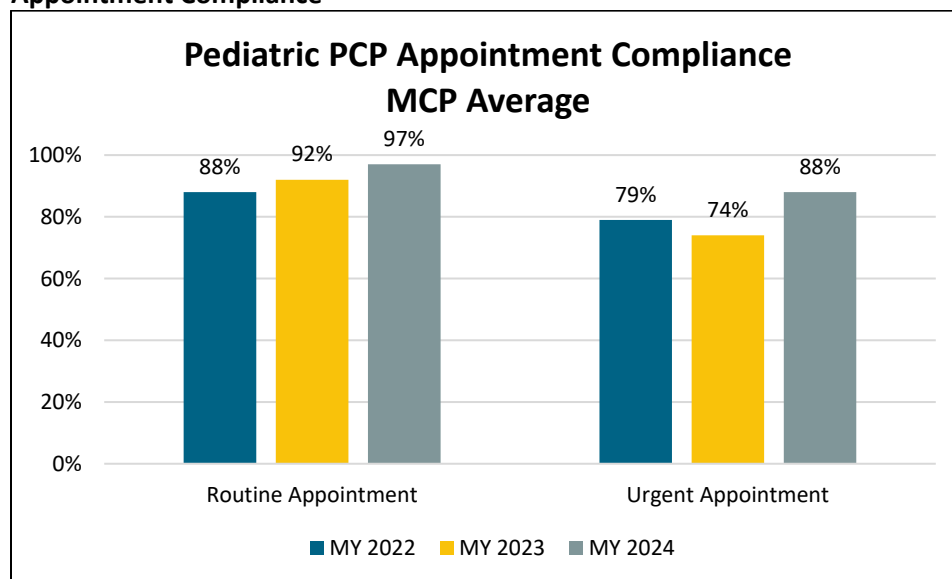
Figure 16. MYs 2022-2024 DCHFP and CASSIP MCP Average Adult PCP Appointment Compliance

Figure 17. MYs 2022-2024 DCHFP and CASSIP MCP Average Pediatric PCP Appointment Compliance



DDCP Survey Results. Qlarant surveyed all LTSS providers during 2024. Table 54 displays results of key provider access and availability measures for each LTSS provider type and LTSS average.

Table 54. MY 2024 DDCP MCP Key Provider Access and Availability Measure Results

2024 Access and Availability	Adult Day Health Program	Assisted Living Facilities	Chore/Homemaker Service	Home Health Agencies	Medical Alert Devices/Services	Nursing Facilities	LTSS Provider Average
Successful contact with provider	50%	60%	25%	67%	0%	67%	58%
Provider accepts the listed MCP	100%	100%	100%	84%	0%	100%	85%
Provider appeared in the online provider directory	100%	100%	100%	100%	100%	100%	100%
Provider accepts new patients	100%	67%	100%	100%	NA	100%	97%

NA – Not applicable as the provider was not successfully contacted. Surveyors attempted to contact all three Medical Alert Devices/Services Providers. In one instance the surveyor did not reach the intended provider and in the other two instances, the surveyor reached the provider, but was informed the provider did not accept the insurance. When the surveyor is informed the provider does not accept the insurance, the survey ends.

Up to three attempts were made to contact each provider. The successful contact average was 58%. Unsuccessful contacts were most frequently due to “reached voicemail” (52%). Of the surveyed providers, 85% indicated they accepted UHC insurance and 97% stated they were accepting new patients. All providers were located in the online provider directory (100%).

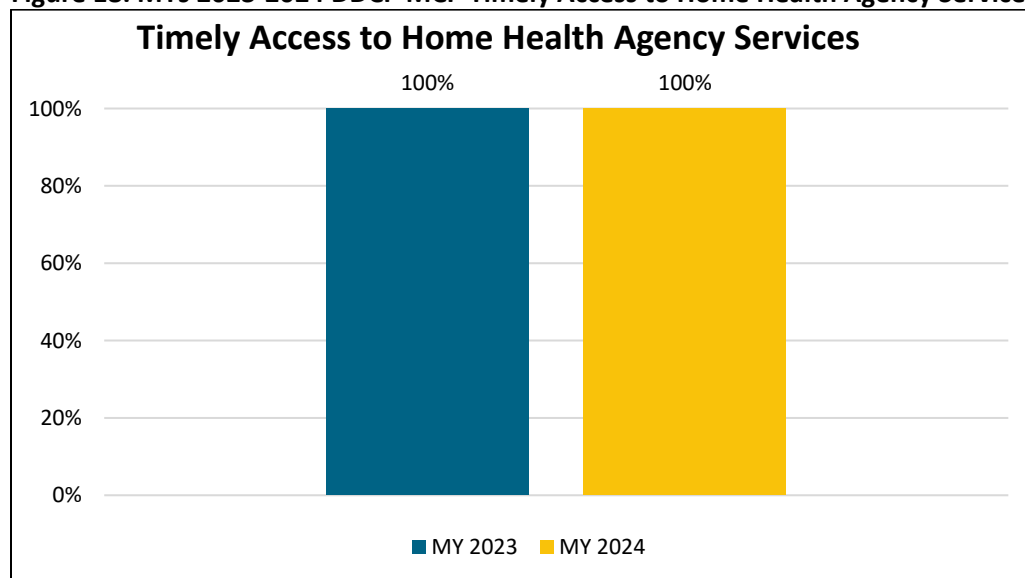
Table 55 displays UHC's compliance with its single timely access standard: home health agency covered services should be initiated within 72 hours of acceptance of a referral.

Table 55. MY 2024 DDCP MCP Timely Access to Home Health Agency Services

2024 Access and Availability	UHC
Home Health Agency – services should be initiated within 72 hours of acceptance of a referral	100%

Home health agency survey results indicated services could be initiated anywhere from same day to within three days of request. Figure 18 includes UHC's compliance with timely access to home health agency services for MYs 2023-2024. UHC achieved 100% compliance in both annual surveys.

Figure 18. MYs 2023-2024 DDCP MCP Timely Access to Home Health Agency Services



Provider Directory Accuracy

DCHFP and CASSIP Provider Directory Validation. Table 56 provides MY 2024 MCP overall accuracy of provider directory validation results compared to the MCP average of 41%. As described in the NAV methodology, each provider directory listing must meet eight criteria in order to be assessed as fully accurate.

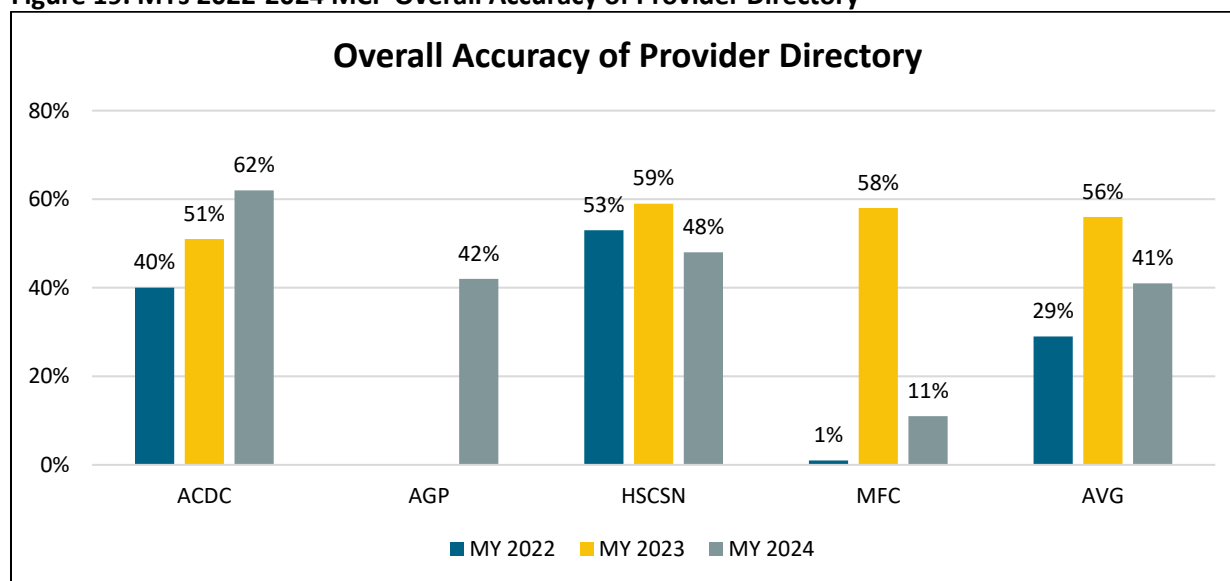
Table 56. MY 2024 MCP Overall Accuracy of Provider Directory

2024 Access and Availability	ACDC	AGP	HSCSN	MFC	MCP AVG
Overall Accuracy of Provider Directory	62%	42%	48%	11%	41%

ACDC, AGP, and HSCSN exceeded the overall accuracy of provider directory MCP average, while MFC performed well below the average at 11%. Most frequently, MFC's poor performance was attributed to a combination of the provider not being with the practice or providing the desired services, not accepting the listed insurance, and the address not matching what is identified in the online provider directory.

Figure 19 illustrates overall provider directory accuracy compared to the MCP averages, and trended from MYs 2022–2024.

Figure 19. MYs 2022-2024 MCP Overall Accuracy of Provider Directory



CFDC contributed to the average in MY 2022.

Results are not available for AGP prior to 2024; the MCP's contract was effective April 1, 2023.

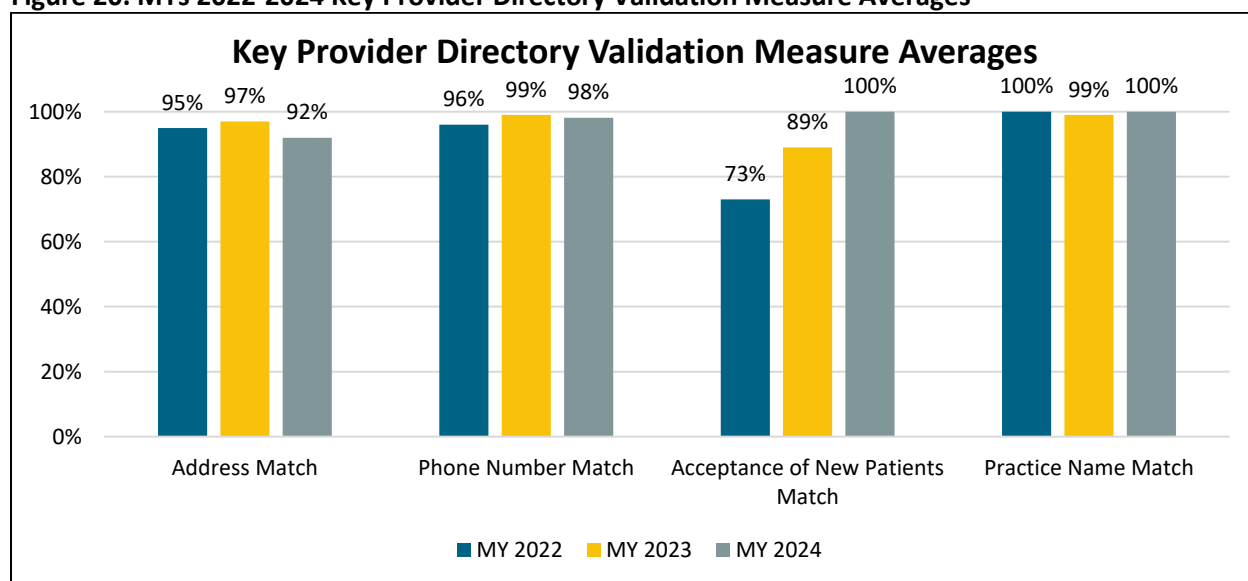
While HSCSN and MFC's performance declined over this last year, ACDC demonstrated a positive three-year trend in provider directory accuracy. The MCP average for overall accuracy declined 15 percentage points from 56% in MY 2023 to 41% in MY 2024. This decline in performance is primarily attributed to MFC's performance (11% in MY 2024).

Table 57 displays four key provider directory validation measures critical to enrollees in their search for a provider.

Table 57. MY 2024 Key Provider Directory Validation Measures by MCP

2024 Access and Availability	ACDC	AGP	HSCSN	MFC	MCP AVG
Address Match	93%	90%	94%	83%	92%
Phone Number Match	100%	95%	98%	100%	98%
Acceptance of New Patients Match	100%	100%	100%	100%	100%
Practice Name Match	100%	100%	100%	100%	100%

The inaccuracy of addresses appearing in provider directories presents the most significant opportunity for improvement. Figure 20 includes key provider directory validation measure MCP averages for MYs 2022-2024.

Figure 20. MYs 2022-2024 Key Provider Directory Validation Measure Averages

Acceptance of New Patients Match demonstrated a positive trend in performance over the three-year period. After achieving an improvement in MY 2023, the Address Match indicator fell five percentage points, from 97% to 92%, in MY 2024. Phone Number Match and Practice Name Match results remain relatively high.

DDCP Provider Directory Validation. Table 58 includes MY 2024 UHC provider directory validation results for LTSS providers compared to the LTSS provider average of 65%. Each provider directory listing must meet six criteria in order to be assessed as fully accurate.

Table 58. MY 2024 DDCP MCP Overall Accuracy of Provider Directory – LTSS Providers

2024 Access and Availability	Adult Day Health Program	Assisted Living Facilities	Chore/Homemaker Service	Home Health Agencies	Medical Alert Devices/Services*	Nursing Facilities	LTSS Provider Average
Overall Provider Directory Accuracy	33%	67%	25%	70%	0%	92%	65%

Only one LTSS provider, nursing facilities, performed above 90% in regard to overall provider directory accuracy. Figure 21 illustrates overall provider directory accuracy averages from MYs 2022–2024.

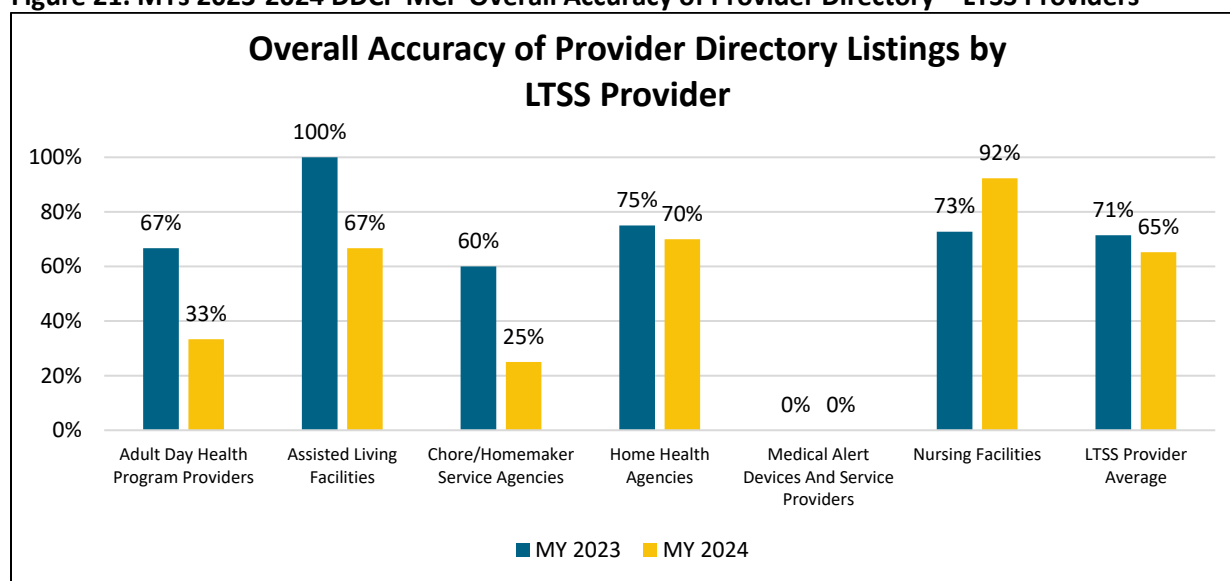
Figure 21. MYs 2023-2024 DDCP MCP Overall Accuracy of Provider Directory – LTSS Providers

Table 59 includes key provider directory indicators, which are critical for enrollee access: Address Match, Phone Number Match, Acceptance of New Patients Match, and Practice Name Match. “Matches” were verified during the surveys to ensure accurate information is provided to enrollees.

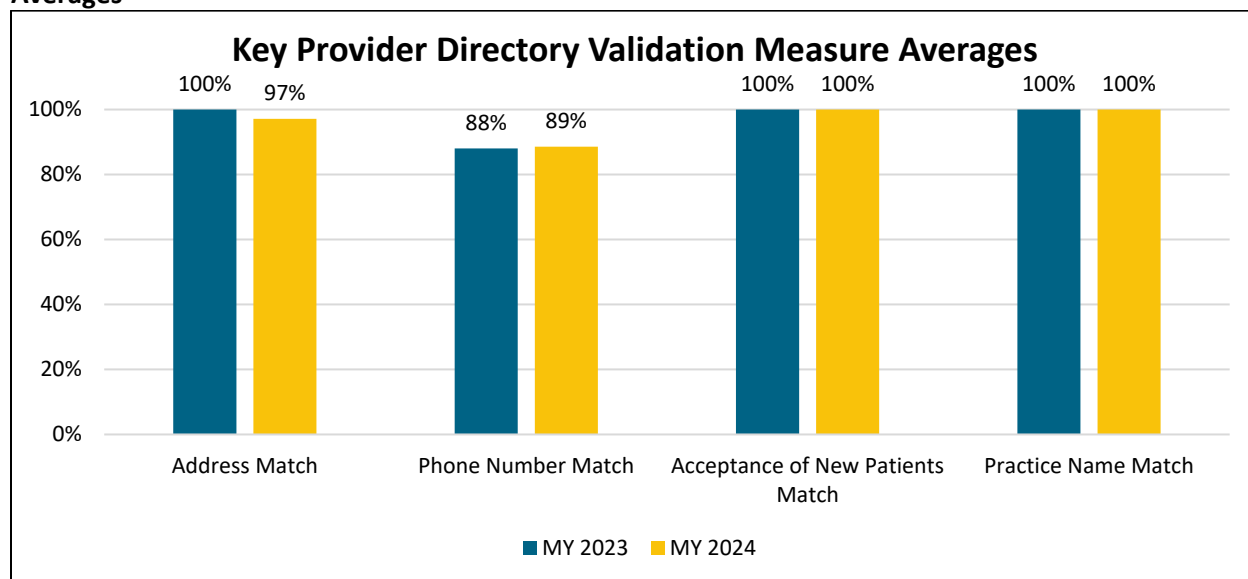
Table 59. MY 2024 DDCP MCP Key Provider Directory Validation Measures – LTSS Providers

2024 Access and Availability	Adult Day Health Program	Assisted Living Facilities	Chore/Homemaker Service	Home Health Agencies	Medical Alert Devices/Services	Nursing Facilities	LTSS Provider Average
Address Match	100%	100%	100%	94%	NA	100%	97%
Phone Number Match	33%	67%	100%	94%	NA	100%	89%
Acceptance of New Patients Match	100%	100%	100%	100%	NA	100%	100%
Practice Name Match	100%	100%	100%	100%	NA	100%	100%

NA – Not applicable as the provider was not successfully contacted. Surveyors attempted to contact all three Medical Alert Devices/Services Providers. In one instance the surveyor did not reach the intended provider and in the other two instances, the surveyor reached the provider, but was informed the provider did not accept the insurance. When the surveyor is informed the provider does not accept the insurance, the survey ends.

The Medical Alert Devices/Services Providers were not successfully contacted; therefore, the provider directory measures could not be assessed. All other LTSS providers were fully compliant in the following measures: Acceptance of New Patients Match and Practice Name Match. The Phone Number Match indicator was the lowest performing measure. The DDCP MCP averages for the key provider directory validation measures are displayed in Figure 22.

Figure 22. MYs 2023-2024 DDCP MCP Key Provider Directory Validation Measures – LTSS Provider Averages



Conclusion

Aggregate summary conclusions for the NAV activities are described below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 60-64, within the [MCP Quality, Access, Timeliness Assessment](#) section.

- All MCPs have robust networks. DCHFP and CASSIP enrollees have access to at least 2 PCPs within 5 miles or 30 minutes of their residences. UHC enrollees have sufficient and timely access to the following LTSS providers: adult day health programs, assisted living facilities, and nursing facilities. UHC contracts with the minimum number of providers for all LTSS types.
- DCHFP and CASSIP MCP adult and pediatric PCP access for routine and urgent care survey results demonstrate compliance ratings ranging from 77%-100% for MY 2024. MCP averages reveal the following timely access compliance ratings: 93% for adults accessing routine care, 87% for adults accessing urgent care, 97% for children accessing routine care, and 88% for children accessing urgent care.
- DCHFP and CASSIP access to adult routine and urgent care and pediatric routine and urgent care improved during MY 2024, compared to MY 2023, based on MCP averages.
- DDCP D-SNP enrollees have access to home health agency covered services within 72 hours of acceptance of a referral; UHC achieved 100 percent compliance with this standard.
- Overall accuracy of DCHFP and CASSIP MCP online provider directories ranged from 11% (MFC) to 62% (ACDC) for MY 2024. The MCP average was 41%; the MCP average declined by 15 percentage points when compared to previous annual performance (56% to 41%). The overall accuracy DDCP D-SNP provider directory accuracy was 65% for LTSS providers for MY 2024; this is a six percentage point decline compared to the MY 2023 average of 71%.
- Surveyors attempted to contact all three Medical Alert Device/Service Providers for the DDCP D-SNP survey. In one instance the surveyor did not reach the intended provider and in the other two instances, the surveyor reached the provider, but was informed the provider did not accept the insurance. When the surveyor is informed the provider does not accept the insurance, the

survey ends. For these reasons, limited results are available for the Medical Alert Device/Service Providers.

MCP Quality, Access, Timeliness Assessment

Quality, Access, Timeliness

Qlarant identified strengths and weaknesses for each MCP, based on the results of the EQR activities. These strengths and weaknesses correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for these domains:

Quality, Access, and Timeliness Definitions

Quality, as stated in the federal regulations as it pertains to EQR, is the degree to which an MCP “...increases the likelihood of desired outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidenced-based-knowledge, and (3) interventions for performance improvement.” (CFR §438.320).

Access (or accessibility), as defined by NCQA, is “the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services” (*NCQA Health Plan Standards and Guidelines*).

Timeliness, as stated by the Institute of Medicine is “reducing waits and sometimes harmful delays” and is interrelated with safety, efficiency, and patient-centeredness of care. Long waits in physicians’ offices or emergency rooms and long waits for test results may result in physical harm. For example, a delay in test results can cause delayed diagnosis or treatment—resulting in preventable complications.

Tables 60-64 highlight strengths and weaknesses for each MCP identified during the 2024 EQR activities. Identified strengths and weaknesses correspond to the quality, access, and/or timeliness of services delivered to MCP enrollees. Only applicable domains for each strength or weakness are identified with a (★) or (●), indicating a positive or negative impact, as described below. Not all domains were impacted by each strength or weakness; in these instances, “NA” is displayed indicating not applicable. Where appropriate, weaknesses include recommendations.

- ★ The MCP strength identified positively impacts quality, access, and/or timeliness.
- The MCP weakness identified negatively impacts quality, access, and/or timeliness.

Examples of the quality, access, and timeliness analysis include:

- If the MCP demonstrated full compliance in the Quality Assessment and Performance Improvement Program Standard, performance would be identified with a ★ in the quality domain.

- If the MCP did *not* provide female enrollees with direct access to a women's health specialist to provide routine and preventive health care services, performance would be identified with a ● in the access domain.
- If the MCP demonstrated statistically significant improvement in an Annual Dental Visits PIP measure, performance would be identified with a ★ in all three domains, as the PIP is a quality project, which focuses on improving access to preventive dental care in a timely manner.

ACDC

Table 60. ACDC Strengths, Weaknesses, and Recommendations identified during 2024 EQR Activities

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Behavioral Health PIP			
★	★	★	Strength. ACDC received an overall PIP validation score of 100% (high confidence). The MCP provided a meaningful project rationale, completed a comprehensive baseline data analysis, and identified barriers to target to improve performance.
Maternal Health PIP			
★	★	★	Strength. ACDC received an overall PIP validation score of 100% (high confidence). The MCP provided a meaningful project rationale, completed a comprehensive baseline data analysis, and identified barriers to target to improve performance.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Measure Set Performance Measures			
★	★	★	Strength. ACDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
EPSDT Performance Measures			
★	★	★	Strength. ACDC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	Strength. ACDC received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers, and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	Strength. ACDC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	Strength. ACDC received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
MCO Standards			
★	★	★	Strength. ACDC received a score of 99.12% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
NA	★	★	Strength. ACDC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
NA	●	NA	Weakness. ACDC did not meet all DHCF-established provider network standards for all provider types. Recommendation. ACDC should ensure it is meeting all DHCF-established provider network standards and report compliance of all required provider types in its 2025 geographic access reports.
MCO Standards – Coordination and Continuity of Care			
★	★	★	Strength. ACDC provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	Strength. ACDC provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★	NA	Strength. ACDC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★	NA	NA	Strength. ACDC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★	NA	NA	Strength. ACDC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	Strength. ACDC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★	NA	NA	Strength. ACDC provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★	NA	NA	Strength. ACDC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
★	★	★	Strength. ACDC received a score of 99.11% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.
●	NA	●	Weakness. ACDC did not adequately follow its policies on grievances and appeals in regard to committee review/analysis. Recommendation. ACDC should amend its policies on grievances and appeals in regard to responsible committees for reviewing data, identifying opportunities for improvement, and developing and monitoring action plans, along with meeting frequency.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
NETWORK ADEQUACY VALIDATION			
★	★	★	Strength. ACDC received a high confidence rating for each indicator it reported in its Provider Network Report. Stakeholders can have high confidence in the MCP's data collection procedures, methods of analysis, and interpretation of results. The MCP's report can confidently be used to gauge compliance with network adequacy standards.
●	●	●	Weakness. ACDC omitted three indicators from its Provider Network Report. These indicators are required by DHCF to gauge compliance with network adequacy standards. Recommendation. ACDC should include the missing indicators in future Provider Network Reports to DHCF.
ENCOUNTER DATA VALIDATION			
★	NA	NA	Strength. ACDC achieved an encounter data accuracy, or match rate, of 95.0%. Stakeholders can have high confidence in the quality of the MCP's encounter/claims data.
NETWORK ADEQUACY SURVEY FOCUS STUDY			
NA	★	★	Strength. ACDC provided evidence of maintaining a PCP network meeting DHCF geographic and provider-to-enrollee ratio requirements.
NA	●	●	Weakness. ACDC received a score of 88% for timely access to adult routine appointments. Recommendation. ACDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.
NA	★	★	Strength. ACDC received a score of 92% for timely access to adult urgent appointments.
NA	★	★	Strength. ACDC received a score of 100% for timely access to pediatric routine appointments.
NA	●	●	Weakness. ACDC received a score of 88% for timely access to pediatric urgent appointments. Recommendation. ACDC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.
●	●	NA	Weakness. ACDC received a score of 62% for overall provider directory accuracy. Most inaccuracies are attributed to provider office staff indicating the surveyed provider is not with the practice or does not provide the desired services. Recommendation. ACDC should make provider directory accuracy a priority and update information routinely.

AGP

Table 61. AGP Strengths, Weaknesses, and Recommendations identified during 2024 EQR Activities

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Behavioral Health PIP			
●	NA	NA	Weakness. AGP received an overall score of 85.7% (moderate confidence). AGP stated it will use administrative data in calculating the performance measures; however, the MCP failed to answer PIP questions related to how it intends to collect administrative data. The MCP was instructed of this requirement in the last annual PIP proposal evaluation. Recommendation. AGP should amend its data collection plan and respond to all relevant administrative data collection plan questions, as specified in the PIP reporting template.
Maternal Health PIP			
★	★	★	Strength. AGP received an overall PIP validation score of 100% (high confidence). The MCP provided a meaningful project rationale, identified a comprehensive data collection plan, and identified barriers to target to improve performance.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Measure Set Performance Measures			
★	★	★	Strength. AGP received a score of 100% (high confidence). Information systems were adequate and the MCP is prepared to report measures during the next annual cycle.
EPSDT Performance Measures			
★	★	★	Strength. AGP received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as “reportable.”
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	Strength. AGP received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers, and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	Strength. AGP received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	Strength. AGP received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.
MCO Standards			

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
★	★	★	Strength. AGP received a score of 98.25% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	Strength. AGP provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
NA	●	NA	Weakness. AGP did not meet all DHCF-established provider network standards for all provider types. Recommendation. AGP should ensure it is meeting all DHCF-established provider network standards and report compliance of all required provider types in its 2025 geographic access reports.
MCO Standards – Coordination and Continuity of Care			
★	★	★	Strength. AGP provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	Strength. AGP provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
●	NA	NA	Weakness. While AGP reports a review of EPSDT provider training occurs, verification is not being documented on the Credentials Verification Checklist. Recommendation. AGP should amend its credentialing verification checklist and show evidence that provider EPSDT training was assessed for all PCPs serving enrollees birth to 21 years of age.
MCO Standards – Confidentiality			
★	NA	NA	Strength. AGP provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★	NA	NA	Strength. AGP provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	Strength. AGP provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★	NA	NA	Strength. AGP provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★	NA	NA	Strength. AGP received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and plans to monitor performance.
Grievance and Appeal System			
★	★	★	Strength. AGP received a score of 98.21% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●	●	NA	Weakness. A random sample review of adverse benefit determination letters found procedures for requesting an appeal; however, in some letters written confirmation of an oral appeal was incorrectly required. Recommendation. AGP should delete language that requires written confirmation of an oral appeal from all adverse benefit determination letter templates.
●	NA	NA	Weakness. A random sample review of appeal records found inconsistent compliance in documenting the date the resolution process was completed in the appeal resolution letters. Overall compliance with including the date the resolution process was completed was 83%. Recommendation. AGP should provide the date the resolution process was completed in all appeal resolution letters.
NETWORK ADEQUACY VALIDATION			
★	★	★	Strength. AGP received a high confidence rating for each indicator it reported in its Provider Network Report. Stakeholders can have high confidence in the MCP's data collection procedures, methods of analysis, and interpretation of results. The MCP's report can confidently be used to gauge compliance with network adequacy standards.
●	●	●	Weakness. AGP omitted four indicators from its Provider Network Report. These indicators are required by DHCF to gauge compliance with network adequacy standards. Recommendation. AGP should include the missing indicators in future Provider Network Reports to DHCF.
ENCOUNTER DATA VALIDATION			
★	NA	NA	Strength. AGP achieved an encounter data accuracy, or match rate, of 97.6%. Stakeholders can have high confidence in the quality of the MCP's encounter/claims data.
NETWORK ADEQUACY SURVEY FOCUS STUDY			
NA	★	★	Strength. AGP provided evidence of maintaining a PCP network meeting DHCF geographic and provider-to-enrollee ratio requirements.
NA	★	★	Strength. AGP received a score of 92% for timely access to adult routine appointments.
NA	●	●	Weakness. AGP received a score of 88% for timely access to adult urgent appointments. Recommendation. AGP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.
NA	★	★	Strength. AGP received a score of 100% for timely access to pediatric routine appointments.
NA	★	★	Strength. AGP received a score of 95% for timely access to pediatric urgent appointments.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●	●	NA	Weakness. AGP received a score of 42% for overall provider directory accuracy. Most inaccuracies are attributed to provider office staff indicating the surveyed provider is not with the practice or does not provide the desired services. Recommendation. AGP should make provider directory accuracy a priority and update information routinely.

HSCSN

Table 62. HSCSN Strengths, Weaknesses, and Recommendations identified during 2024 EQR Activities

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Behavioral Health PIP			
★	★	★	Strength. HSCSN received an overall PIP validation score of 100% (high confidence). The MCP provided a meaningful project rationale, completed a comprehensive baseline data analysis, and identified barriers to target to improve performance.
Childhood Obesity Management and Prevention PIP			
●	NA	NA	Weakness. HSCSN received an overall PIP validation score of 84.0%. Multiple issues were identified. The aim statement was not concise and did not fully address interventions to improve performance in the selected measures. The MCP did not identify two key variables: nutrition and physical activity counseling, which are critical to supporting the PIP aim/study question. The MCP's analysis included errors. The MCP did not demonstrate its reported improvement was likely the result of selected improvement strategies; nor did it achieve statistically significant improvement in at least one measure. Recommendation. HSCSN should: amend its aim statement to address interventions; identify key variables critical to the success of the PIP; ensure its analysis is accurate; demonstrate any improvement is likely the result of interventions, which would include an assessment of each intervention on the selected performance measure; and achieve statistically significant improvement in at least one measure.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Measure Set Performance Measures			
★	★	★	Strength. HSCSN received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
EPSTD Performance Measures			
★	★	★	Strength. HSCSN received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
★	★	★	Strength. HSCSN received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers, and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	Strength. HSCSN received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	Strength. HSCSN received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.
MCO Standards			
★	★	★	Strength. HSCSN received a score of 99.12% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	Strength. HSCSN provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
NA	●	NA	Weakness. HSCSN did not meet all DHCF-established provider network standards for all provider types. Recommendation. HSCSN should ensure it is meeting all DHCF-established provider network standards and report compliance of all required provider types in its 2025 geographic access reports.
MCO Standards – Coordination and Continuity of Care			
★	★	★	Strength. HSCSN provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	Strength. HSCSN provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★	NA	Strength. HSCSN provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★	NA	NA	Strength. HSCSN provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★	NA	NA	Strength. HSCSN provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	Strength. HSCSN provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
★	NA	NA	Strength. HSCSN provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★	NA	NA	Strength. HSCSN received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
NA	NA	●	Weakness. A random sample review of grievance and appeal records found inconsistent compliance in meeting the two-business day timeframe for sending the enrollee an acknowledgment letter. Compliance was 57% and 91%, respectively. Recommendation. HSCSN should demonstrate consistent compliance with the timeframe requirements for sending enrollees written grievance and appeal acknowledgments (two business days).
●	●	NA	Weakness. HSCSN's policy on appeals requires oral appeals be confirmed in writing. This is an outdated requirement that was removed from the CFR. Recommendation. HSCSN should update its policy on appeals and eliminate language that requires oral appeals be confirmed in writing.
NA	NA	●	Weakness. A random sample review of grievance records found inconsistent compliance in meeting the 90-calendar day resolution notice timeframe for standard grievances. Compliance was 67%. Recommendation. HSCSN should demonstrate consistent compliance with the resolution notice timeframe for standard grievances (90 calendar days).
NA	●	●	Weakness. A random sample review of appeal records found inconsistent compliance in meeting the resolution notification timeframe of 30 calendar days from receipt of the standard appeal. Compliance was 58%. Recommendation. HSCSN should demonstrate consistent compliance in meeting the resolution notification timeframe of 30 calendar days from receipt of the standard appeal.
●	NA	●	Weakness. In a random sample review of appeal records, one request for an extension was found which demonstrated compliance with the requirement for providing the enrollee written notice of the reason for the extension; however, there was no evidence found in case notes that HSCSN made a reasonable attempt to provide the enrollee oral notice of the delay. Recommendation. HSCSN should demonstrate a reasonable attempt was made to provide the enrollee with prompt oral notice of the decision to extend the appeal timeframe.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●	NA	●	Weakness. In a random sample review of appeal records, one expedited request was found with no documentation supporting a reasonable attempt to provide the enrollee with oral notice of the resolution. Review of case notes for the two additional expedited requests within the remaining sample of valid records also found no evidence of oral notice. Overall compliance with oral notice of an expedited appeal resolution was 0%. Recommendation. HSCSN should demonstrate consistent compliance in making reasonable efforts to provide the enrollee with oral notice of an expedited appeal resolution.
●	NA	NA	Weakness. A random sample review of appeal records found inconsistent compliance in documenting the date of the appeal resolution within the appeal resolution letters. One record was missing the appeal resolution letter. Compliance was 91%. Recommendation. HSCSN should consistently develop appeal resolution letters and include results of the resolution process and the date it was completed.
●	●	●	Weakness. A random sample review of appeal records found inconsistent compliance in resolution letters including communicating enrollee rights and procedures for requesting a fair hearing and continuation of benefits. Two records were missing a resolution letter. Overall compliance was 91%. Recommendation. HSCSN should consistently include in all appeal resolution letters the rights of the enrollee and procedures for requesting a fair hearing and continuation of benefits.
●	NA	NA	Weakness. Neither the appeals nor fair hearings policies identified the parties to the District Fair Hearing. Recommendation. HSCSN should specify in either its appeals policy or fair hearings policy, the parties to the District Fair Hearing.
●	NA	NA	Weakness. Review of minutes from six Appeals and Grievances Committee meetings held in 2024 found no evidence of analysis of grievance or appeal trends, identification of opportunities for improvement, development of action plans, or monitoring of their effectiveness. Recommendation. HSCSN should revise its policies on grievances and appeals to specify the responsibilities of the Grievance and Appeal Committee for identifying opportunities for improvement based upon trend analysis, developing action plans in response, and monitoring and evaluating the effectiveness of these plans. The frequency of these meetings needs to be included, as well as the frequency of reporting to the Quality Management Outcomes Committee. Meeting minutes from these committees should demonstrate compliance with these policies.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●	NA	NA	Weakness. DHCF prohibits MCPs from recovering payment for services while a District Fair Hearing is pending. This requirement was omitted from HSCSN's policies on appeal and fair hearings. Recommendation. HSCSN should revise its policies on appeals and fair hearings to specify that the MCP will not recover payment for services furnished while a District Fair Hearing is pending if the final resolution is adverse to the enrollee.
●	NA	NA	Weakness. HSCSN's policy on fair hearings does not sufficiently address the requirement that if the District Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCP must pay for those services. Recommendation. HSCSN should revise its policy on fair hearings to specify that if the District Fair Hearing Officer reverses a decision to deny authorization of services, HSCSN must pay for those services furnished while the appeal is pending.
NETWORK ADEQUACY VALIDATION			
★	★	★	Strength. HSCSN received a high confidence rating for each indicator it reported in its Provider Network Report. Stakeholders can have high confidence in the MCP's data collection procedures, methods of analysis, and interpretation of results. The MCP's report can confidently be used to gauge compliance with network adequacy standards.
●	●	●	Weakness. HSCSN omitted 17 indicators from its Provider Network Report. These indicators are required by DHCF to gauge compliance with network adequacy standards. Recommendation. HSCSN should include the missing indicators in future Provider Network Reports to DHCF.
ENCOUNTER DATA VALIDATION			
●	NA	NA	Weakness. HSCSN scored 90.9% in the encounter data validation study; this score provides a moderate level of confidence in the MCP's encounter data. Most "No Match" findings were primarily due to lack of supporting documentation for diagnosis codes in the medical record. Recommendation. HSCSN should educate its providers on including sufficient documentation in the medical records, to support codes for billed claims.
NETWORK ADEQUACY SURVEY FOCUS STUDY			
NA	★	★	Strength. HSCSN provided evidence of maintaining a PCP network meeting DHCF geographic and provider-to-enrollee ratio requirements.
NA	★	★	Strength. HSCSN received a score of 95% for timely access to adult routine appointments.
NA	●	●	Weakness. HSCSN received a score of 85% for timely access to adult urgent appointments. Recommendation. HSCSN should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
NA	★	★	Strength. HSCSN received a score of 96% for timely access to pediatric routine appointments.
NA	★	★	Strength. HSCSN received a score of 92% for timely access to pediatric urgent appointments.
●	●	NA	Weakness. HSCSN received a score of 48% for overall provider directory accuracy. Most inaccuracies are attributed to provider office staff indicating the surveyed provider is not with the practice or does not provide the desired services. Recommendation. HSCSN should make provider directory accuracy a priority and update information routinely.

MFC

Table 63. MFC Strengths, Weaknesses, and Recommendations identified during 2024 EQR Activities

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Behavioral Health PIP			
★	★	★	Strength. MFC received an overall PIP validation score of 100% (high confidence). The MCP provided a meaningful project rationale, completed a comprehensive baseline data analysis, and identified barriers to target to improve performance.
Maternal Health PIP			
★	★	★	Strength. MFC received an overall PIP validation score of 94.6% (high confidence). The MCP provided a meaningful project rationale, completed a comprehensive baseline data analysis, and identified barriers to target to improve performance.
●	NA	NA	Weakness. MFC provided examples of variables such as clinical outcomes, patient experience, process improvement, and safety variables, none of which specifically addressed variables used to answer the PIP study question. Recommendation. MFC should identify objective, clearly defined, time specific variables that support the Maternal Health PIP study question, such as first trimester prenatal visit for women who had a delivery during the MY and postpartum visit for women who had a delivery during the MY.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Set Performance Measures			
★	★	★	Strength. MFC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as “reportable.”
EPSDT Performance Measures			
★	★	★	Strength. MFC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as “reportable.”
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
★	★	★	Strength. MFC received a score of 100% (high confidence) in the Information Requirements Standard. The MCP communicates required information on benefits and providers, and how to access services.
Disenrollment Requirements and Limitations			
★	★	★	Strength. MFC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	Strength. MFC received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.
MCO Standards			
★	★	★	Strength. MFC received a score of 99.12% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
	★	★	Strength. MFC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
NA	●	NA	Weakness. MFC did not meet all DHCF-established provider network standards for all provider types. Recommendation. MFC should ensure it is meeting all DHCF-established provider network standards and report compliance of all required provider types in its 2025 geographic access reports.
MCO Standards – Coordination and Continuity of Care			
★	★	★	Strength. MFC provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	Strength. MFC provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★	NA	Strength. MFC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★	NA	NA	Strength. MFC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★	NA	NA	Strength. MFC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	Strength. MFC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★	NA	NA	Strength. MFC provided evidence of meeting all Health Information Systems requirements.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
Quality Assessment and Performance Improvement Program			
★	NA	NA	Strength. MFC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
★	★	★	Strength. MFC received a score of 100% (high confidence) in the Grievance and Appeal System Standard. The MCP demonstrated compliance with resolving grievances and appeals, and providing enrollee notification of resolution, consistent with District and federal requirements.
NETWORK ADEQUACY VALIDATION			
★	★	★	Strength. MFC received a high confidence rating for all but one indicator it reported in its Provider Network Report. Stakeholders can have high confidence in the MCP's data collection procedures, methods of analysis, and interpretation of results. The MCP's report can confidently be used to gauge compliance with network adequacy standards.
●	●	●	Weakness. MFC received a moderate confidence rating in its pharmacy indicator. The MCP completed its calculation based upon access to one or more pharmacies, rather than two or more pharmacies, as required. Recommendation. MFC should ensure it calculates the pharmacy indicator in a manner consistent with DHCF requirements. Adequate access is measured using two or more pharmacies, rather than one or more.
●	●	●	Weakness. MFC omitted 13 indicators from its Provider Network Report. These indicators are required by DHCF to gauge compliance with network adequacy standards. Recommendation. MFC should include the missing indicators in future Provider Network Reports to DHCF.
ENCOUNTER DATA VALIDATION			
●	NA	NA	Weakness. MFC scored 92.8% in the encounter data validation study; this score provides a moderate level of confidence in the MCP's encounter data. Most "No Match" findings were due to lack of supporting documentation for diagnosis and procedure codes in the medical record. Recommendation. MFC should educate its providers on including sufficient documentation in the medical records, to support codes for billed claims.
NETWORK ADEQUACY SURVEY FOCUS STUDY			
NA	★	★	Strength. MFC provided evidence of maintaining a PCP network meeting DHCF geographic and provider-to-enrollee ratio requirements.
NA	★	★	Strength. MFC received a score of 100% for timely access to adult routine appointments.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
NA	●	●	Weakness. MFC received a score of 81% for timely access to adult urgent appointments. Recommendation. MFC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.
NA	★	★	Strength. MFC received a score of 92% for timely access to pediatric routine appointments.
NA	●	●	Weakness. MFC received a score of 77% for timely access to pediatric urgent appointments. Recommendation. MFC should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.
●	●	NA	Weakness. MFC received a score of 11% for overall provider directory accuracy. Most inaccuracies are attributed to inaccurate provider office addresses. Recommendation. MFC should make provider directory accuracy a priority and update information routinely.

UHC

Table 64. UHC Strengths, Weaknesses, and Recommendations identified during 2024 EQR Activities

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
PERFORMANCE IMPROVEMENT PROJECTS			
Behavioral Health PIP			
★	★	★	Strength. UHC received an overall PIP validation score of 100% (high confidence). The MCP provided a meaningful project rationale, completed a comprehensive baseline data analysis, and identified barriers to target to improve performance.
Fall Risk Management PIP			
★	★	★	Strength. UHC received an overall PIP validation score of 100% (high confidence). The MCP reported a methodologically sound PIP and achieved improvement in all PIP measures. In two of three measures, the improvement was statistically significant.
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Set Performance Measures			
★	★	★	Strength. UHC received a score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as “reportable.”
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
★	★	★	Strength. UHC received a score of 96.67% in the Information Requirements Standard, contributing to the MCP’s overall high confidence score.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●	NA	●	Weakness. UHC did not adequately specify, within a relevant policy, the requirement to provide enrollee notice of provider terminations within the timeframes specified by federal regulations. Recommendation: UHC should document the following in a relevant policy: the MCP must make a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.
●	NA	NA	Weakness. UHC's Evidence of Coverage/Enrollee Handbook does not specify that oral grievances are acknowledged in writing and followed by written resolution. According to UHC staff, if an enrollee contacts Enrollee Services to file a grievance and the grievance is resolved during the call, no written acknowledgment letter or resolution letter are sent unless requested by the enrollees. The DHCF contract, 5.24.14.2, requires enrollees or their designee be notified in writing of the grievance decision. This applies whether the grievance was filed orally or in writing. Recommendation: UHC should revise the Evidence of Coverage/Enrollee Handbook and their processes to require written acknowledgment of grievance receipt and written resolution be sent to the enrollee for all grievances whether the grievance was filed orally or in writing.
Disenrollment Requirements and Limitations			
★	★	★	Strength. UHC received a score of 100% (high confidence) in the Disenrollment Requirements and Limitations Standard. The MCP communicates disenrollment options and procedures to enrollees and has established disenrollment procedures compliant with DHCF requirements.
Enrollee Rights and Protections			
★	★	★	Strength. UHC received a score of 100% (high confidence) in the Enrollee Rights and Protections Standard. The MCP maintains a policy, which includes all enrollee rights and protections, and communicates information to enrollees.
MCO Standards			
★	★	★	Strength. UHC received a score of 100% (high confidence) for the MCO Standards (further defined below).
MCO Standards – Availability of Services			
NA	★	★	Strength. UHC provided evidence of meeting all Availability of Services requirements.
MCO Standards – Assurance of Adequate Capacity and Services			
NA	★	NA	Strength. UHC provided evidence of meeting all Assurance of Adequate Capacity and Services requirements.
MCO Standards – Coordination and Continuity of Care			

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
★	★	★	Strength. UHC provided evidence of meeting all Coordination and Continuity of Care requirements.
MCO Standards – Coverage and Authorization of Services			
★	★	★	Strength. UHC provided evidence of meeting all Coverage and Authorization of Services requirements.
MCO Standards – Provider Selection			
★	★	NA	Strength. UHC provided evidence of meeting all Provider Selection requirements.
MCO Standards – Confidentiality			
★	NA	NA	Strength. UHC provided evidence of meeting all Confidentiality requirements.
MCO Standards – Subcontractual Relationships and Delegation			
★	NA	NA	Strength. UHC provided evidence of meeting all Subcontractual Relationships and Delegation requirements.
MCO Standards – Practice Guidelines			
★	★	★	Strength. UHC provided evidence of meeting all Practice Guidelines requirements.
MCO Standards – Health Information Systems			
★	NA	NA	Strength. UHC provided evidence of meeting all Health Information Systems requirements.
Quality Assessment and Performance Improvement Program			
★	NA	NA	Strength. UHC received a score of 100% in the Quality Assessment and Performance Improvement Program standard. The MCP demonstrated a commitment to quality and monitored performance.
Grievance and Appeal System			
★	★	★	Strength. UHC received a score of 95.61% in the Grievance and Appeal System Standard, contributing to the MCP's overall high confidence score.
●	NA	●	Weakness. UHC reported payment denial letters were suppressed from being sent out to the enrollee when the reason for the denial does not constitute an enrollee liability on the claim. The suppression was put in place to prevent confusion with enrollees that were not responsible for any payment. This is inconsistent with DHCF contractual requirements under C.5.24.8.1.2, which requires a notice of adverse benefit determination be sent "For denial of payment, at the time of the Adverse Benefit Determination affecting the claim." Recommendation. UHC should send notice of an adverse benefit determination at the time of denial of claims payment regardless of whether there is any enrollee liability for payment.

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
●	NA	●	Weakness. A random sample review of grievance and appeal records found inconsistent compliance on providing written acknowledgement within two business days of receiving a grievance or appeal. Compliance was 63% and 40%, respectively. Recommendation. UHC should demonstrate compliance with the two-business day timeframe for sending enrollees written acknowledgment for any standard grievances and written acknowledgment for any appeals.
●	●	●	Weakness. A random sample review of appeal records found inconsistent compliance on meeting the 30 calendar day resolution and notice timeframe. Compliance was 87%. Recommendation. UHC should demonstrate consistent compliance with the 30 calendar day timeframe for standard appeal resolutions, inclusive of written notifications.
●	NA	NA	Weakness. A random sample review of appeal records found inconsistent compliance in including the results of the resolution (missing letter) and documenting the date the resolution was completed within the resolution letters to enrollees. Compliance was 97% and 67%, respectively. It was also determined that when someone, such as a provider, filed an appeal on the enrollee's behalf, UHC copied the enrollee on the resolution letter, rather than sending them the letter directly. Recommendation. UHC should demonstrate consistent compliance with documenting the resolution and the date the resolution was completed within the resolution letters to enrollees. Additionally, if an individual files on behalf of the enrollee, the resolution letter should be addressed to the enrollee and the individual filing the appeal should be copied.
●	NA	NA	Weakness. UHC's internal analysis and reporting, and development of action plans for grievances and appeals was found to be inadequate. Recommendation. UHC should demonstrate action plans are developed and monitored to address identified opportunities for improvement based upon grievance and appeal trends in its Service Quality Improvement Subcommittee quarterly meeting minutes. Additionally, there must be evidence of quarterly reporting of appeals and grievances to the Quality Management and Improvement Committee consistent with UHC policies.
DUAL-ELIGIBLE SPECIAL NEEDS PLAN			
★	★	★	Strength. UHC received a score of 100% in the D-SNP standard. The MCP demonstrated compliance with requirements related to its special needs population.
NETWORK ADEQUACY VALIDATION			

Quality	Access	Timeliness	Strengths, Weaknesses, and Recommendations
★	★	★	Strength. UHC received a high confidence rating for each indicator it reported in its Provider Network Report. Stakeholders can have high confidence in the MCP's data collection procedures, methods of analysis, and interpretation of results. The MCP's report can confidently be used to gauge compliance with network adequacy standards.
●	●	●	Weakness. UHC omitted 11 indicators from its Provider Network Report. These indicators are required by DHCF to gauge compliance with network adequacy standards. Recommendation. UHC should include the missing indicators in future Provider Network Reports to DHCF.
ENCOUNTER DATA VALIDATION			
This task is not required for UHC.			
NETWORK ADEQUACY SURVEY FOCUS STUDY			
NA	★	★	Strength. UHC provided evidence of maintaining a provider network meeting minimum LTSS provider requirements established by DHCF.
NA	★	★	Strength. UHC received a 100% compliance rating for timely access to home health agencies.
●	●	NA	Weakness. UHC received a score of 65% for overall provider directory accuracy. Most inaccuracies are attributed to the surveyed provider office indicating they do not accept UHC's insurance. Recommendation. UHC should make provider directory accuracy a priority and update information routinely.

Assessment of Previous Recommendations

During the course of conducting 2024 EQR activities, Qlarant evaluated MCP compliance in addressing previous annual recommendations.¹⁶ MCPs were expected to remedy 2023 deficiencies and demonstrate full compliance. MCPs not addressing deficiencies are at risk of not being compliant with their contracts. Assessment outcomes, included in Tables 65-69, identify if the MCP adequately addressed 2023 recommendations. Color coded symbols specify results:

- ▲ The MCP adequately addressed the recommendation.
- The MCP demonstrated some improvement, but did not fully address the recommendation.
- ▼ The MCP did not adequately address the recommendation.

ACDC

ACDC adequately addressed five of seven recommendations that could be re-evaluated, demonstrating a 71% compliance rating. Table 65 provides details of the 2024 assessment.

¹⁶ In some instances, one recommendation may summarize or capture multiple, but similar, issues. The number of recommendations per MCP should not be used to gauge MCP performance alone.

Table 65. Assessment of ACDC's Previous Annual Recommendations

2023 Recommendation	2024 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Behavioral Health PIP	
ACDC did not clearly specify its population in the PIP aim statement. The MCP should amend its aim statement and clearly specify the population.	▲ ACDC amended its aim statement and clearly specified the population relevant to the Behavioral Health PIP.
Maternal Health PIP	
ACDC's project population descriptions were not always consistent with performance measure specifications. Performance in both PIP measures compared unfavorably to baseline performance. ACDC should align the population description with the performance measure specifications and achieve improvement in at least one measure through implementation of continuous quality improvement strategies.	▲ ACDC amended its PIP population descriptions to ensure consistency with performance measure specifications. The MCP was not required to address the second recommendation since DHCF elected to "restart" the PIP with a new baseline (MY 2023).
PERFORMANCE MEASURE VALIDATION	
PIP and CMS Core Measure Performance Measures	
There were no formal 2023 recommendations for ACDC.	
EPSDT Performance Measures	
There were no formal 2023 recommendations for ACDC.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
There were no formal 2023 recommendations for ACDC.	
Disenrollment Requirements and Limitations	
There were no formal 2023 recommendations for ACDC.	
Enrollee Rights and Protections	
There were no formal 2023 recommendations for ACDC.	
MCO Standards	
There were no formal 2023 recommendations for ACDC.	
Quality Assessment and Performance Improvement Program	
There were no formal 2023 recommendations for ACDC.	
Grievance and Appeal System	
A random sample review of appeals found inconsistency in meeting the timeframe requirement for sending written acknowledgment of the appeal. Compliance was 88%. ACDC should demonstrate compliance with sending the enrollee written acknowledgment within two business days of receipt of the appeal.	▲ A random sample review of appeals found 100% compliance in meeting the timeframe requirement for sending written acknowledgment of the appeal.
NETWORK ADEQUACY VALIDATION	
Not applicable. The NAV task was conducted for the first time in 2024.	
ENCOUNTER DATA VALIDATION	
There were no formal 2023 recommendations for ACDC.	
NETWORK ADEQUACY SURVEY FOCUS STUDY	

2023 Recommendation	2024 Assessment
ACDC received a score of 88% for timely access to adult urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.	▲ Compliance in obtaining timely adult urgent appointments increased in MY 2024 (92%).
ACDC received a score of 88% for timely access to pediatric routine appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.	▲ Compliance in obtaining timely pediatric routine appointments increased in MY 2024 (100%).
ACDC received a score of 87% for timely access to pediatric urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.	● Compliance in obtaining timely pediatric urgent appointments increased (87% in MY 2023 to 88% in MY 2024). There continues to be opportunity to improve performance for pediatric urgent appointments.
ACDC received a score of 51% for overall provider directory accuracy. The MCP should make provider directory accuracy a priority and update information routinely.	● Overall provider directory accuracy improved from 51% in MY 2023 to 62% in MY 2024. There continues to be opportunity to improve provider directory accuracy.

AGP

AGP adequately addressed 14 of 18 recommendations that could be re-evaluated, demonstrating a 78% compliance rating. There were four recommendations that could not be re-evaluated due to the absence of relevant records in the random samples drawn. These items will be re-evaluated during the next annual review. Table 66 provides details of the 2024 assessment.

Table 66. Assessment of AGP's Previous Annual Recommendations

2023 Recommendation	2024 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Behavioral Health PIP	
AGP's aim statement did not meet all requirements and the MCP did not include administrative data collection as part of its data collection plan. AGP should amend its aim statement to clearly specify the improvement strategy, study population, and time period. The MCP should also specify all elements of its data collection plan, including administrative data.	● AGP amended its aim statement and clearly specified the improvement strategy, study population, and time period. However, the MCP failed to answer PIP questions related to how it intends to collect administrative data. This recommendation, related to fully addressing the data collection plan, remains in place.
Maternal Health PIP	
AGP's aim statement did not meet all requirements and the MCP did not include administrative data collection as part of its data collection plan. AGP should amend its aim statement to clearly specify the improvement strategy, study population, and time period. The MCP should also specify all elements of its data collection plan, including administrative data.	▲ AGP amended its aim statement to clearly specify the improvement strategy, study population, and time period. The MCP also amended its data collection plan and successfully addressed administrative data collection requirements.

2023 Recommendation		2024 Assessment	
PERFORMANCE MEASURE VALIDATION			
PIP and CMS Core Measure Performance Measures			
AGP was not required to participate in the 2023 PMV audit due to its April 1, 2023 contract effective date.			
EPSDT Performance Measures			
There were no formal 2023 recommendations for AGP.			
OPERATIONAL SYSTEMS REVIEW			
Information Requirements			
There were no formal 2023 recommendations for AGP.			
Disenrollment Requirements and Limitations			
AGP’s policy on disenrollment failed to address the disenrollment timeframe should DHCF fail to make a timely determination. AGP should amend its policy and state: “If DHCF fails to make a determination on the disenrollment by the first day of the second month following the month the disenrollment was requested by the enrollee, or referred to DHCF by AGP, the disenrollment will be considered approved and the disenrollment date will be no later than the first day of the second month.”		▲ AGP amended its policy on disenrollment to address the recommendation. The policy specifies if DHCF fails to make a determination on the disenrollment by the first day of the second month following the month the disenrollment was requested by the enrollee or referred to DHCF by AGP or an enrollment broker, the disenrollment will be considered approved and the disenrollment date will be no later than the first day of the second month.	
AGP’s policy on disenrollment does not specify timeframes for disenrollment, should the grievance process be utilized. AGP should amend its policy and assert the grievance process for the disenrollment request will be completed in a timeframe to permit disenrollment no later than the first day of the second month following the month in which the enrollee requests disenrollment.		▲ AGP amended its policy on disenrollment to address the recommendation. The policy specifies in regard to grievances, AGP will process the disenrollment request in a timeframe to permit disenrollment no later than the first day of the second month following the month in which the enrollee requests disenrollment. If the enrollee does not experience resolution, AGP shall direct the enrollee to the enrollment broker.	
AGP’s policy on disenrollment fails to address the timeframe for disenrollment determinations regardless of disenrollment procedures followed. AGP should amend its policy and specify the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or AGP refers the request to the DHCF.		▲ AGP amended its policy on disenrollment to address the recommendation. The policy specifies in regard to the effective date of disenrollment, the date must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or AGP refers the request to DHCF.	
AGP’s policy on disenrollment fails to address automatic reenrollment. The requirement is addressed in C.5.21.3 of DHCF’s contract with AGP. AGP should amend its policy and specify it will provide for automatic reenrollment of an enrollee who is disenrolled solely because he or she loses eligibility for a period of two (2) months or less.		▲ AGP amended its policy on disenrollment to specify it will provide for automatic reenrollment of an enrollee who is disenrolled solely because he or she loses eligibility for a period of two (2) months or less.	
Enrollee Rights and Protections			
There were no formal 2023 recommendations for AGP.			
MCO Standards			

2023 Recommendation	2024 Assessment
AGP asserted that EPSDT training review occurs as part of the credentialing process; however, verification is not being documented. AGP should provide a credentialing verification checklist that includes evidence that provider EPSDT training was assessed for all PCPs serving enrollees birth to 21 years of age.	▼ AGP did not provide evidence of a credentialing verification checklist that included evidence that provider EPSDT training was assessed for all PCPs serving enrollees birth to 21 years of age. The recommendation remains in place.
AGP's Master Services Agreement between the MCP and one of its delegates did not include all of the required language related to oversight; performance audits partially address the requirements.	▲ AGP amended its agreement with the delegate and included all required language related to oversight.
Quality Assessment and Performance Improvement Program	
There were no formal 2023 recommendations for AGP.	
Grievance and Appeal System	
AGP's policy on appeals does not accurately identify the enrollee filing timeframe. AGP should amend its policy to state an appeal filing timeframe as 60 calendar days from the date on the adverse benefit determination notice.	▲ AGP's policy on appeals was amended to assert that enrollees and authorized representatives have 60 calendar days to file an appeal from the date on the notice of adverse benefit determination.
A random sample review of adverse benefit determination letters found enrollee procedures requiring oral appeals be confirmed in writing. This is an outdated requirement. AGP must delete language from its adverse benefit determination letter template that requires written confirmation of an oral appeal.	▼ A random sample review continued to find adverse benefit determination letters that included enrollee procedures requiring oral appeals be confirmed in writing. This language must be deleted from the letter template; this recommendation remains in place.
AGP required written notice of an adverse benefit determination for denial of payment be sent to the enrollee within 48 hours, rather than at the time of denial of payment. AGP should amend its policy to require enrollee notices of denial of payment be sent at the time of any action affecting the claim.	▲ AGP amended its policy to specify written notice of an adverse benefit determination for denial of payment be sent to the enrollee at the time of any action affecting the claim.
A random sample review of adverse benefit determination letters found inconsistent compliance with meeting the 14 calendar day timeframe (from receipt of a standard preauthorization request to notice). Compliance was 94%. AGP should demonstrate consistent compliance with the notification timeframe for adverse benefit determinations for standard preauthorization requests (14 calendar days).	▲ A random sample review of adverse benefit determination letters found 100% compliance in meeting the timeframe requirement for standard preauthorization requests.

2023 Recommendation	2024 Assessment
A random sample review of adverse benefit determination letters found inconsistent compliance with meeting the 72 hour timeframe (from receipt of an expedited request to notice). Compliance was 50%. AGP should demonstrate consistent compliance with the notification timeframe for adverse benefit determinations for expedited authorization requests (72 hours).	No requests for expedited authorization were included in the sample. An assessment could not be conducted. The recommendation remains in place. AGP should ensure expedited authorization requests are completed and notice provided within 72 hours.
A random sample review of appeal records found inconsistent compliance with sending the enrollee an acknowledgement of an appeal within two business days of receipt. Compliance was 36%. AGP should demonstrate consistent compliance with sending written acknowledgment of an appeal within two business days of receipt.	▲ A random sample review of appeal records found 100% compliance in meeting the requirement and acknowledging an appeal within two business days of receipt.
AGP's grievance policy asserts grievances involving clinical issues will be reviewed by health care professionals with the appropriate clinical expertise in treating the enrollee's condition. The policy does not specifically address grievances regarding denial of an expedited appeal resolution. AGP should amend its policy to require decision-makers on grievances regarding the denial of an expedited appeal resolution have the appropriate clinical expertise, as determined by DHCF, in treating the enrollee's condition or disease.	▲ AGP amended its grievance policy, which now indicates grievances involving clinical issues as well as grievances regarding denial of an expedited appeal resolution, will be reviewed by health care professionals with the appropriate clinical expertise, as determined by DHCF, in treating the enrollee's condition.
AGP's appeals policy required verbal inquiries seeking to appeal an action be confirmed in writing, unless the enrollee or provider requested expedited resolution. This is inconsistent with regulatory requirements that have eliminated the requirement for written confirmation of an appeal filed orally. A sample review of appeal records found several that required the enrollee to confirm their appeal in writing. Two appeals in the random sample were dismissed due to lack of written confirmation of the appeal by the enrollee. AGP should amend its policy and procedures to eliminate written confirmation of an oral appeal.	▲ AGP amended its appeal policy and removed the requirement that oral appeals be confirmed in writing. A random sample record review did not identify evidence requiring enrollees confirm their oral appeal in writing.
A random sample review found inconsistent compliance in providing written notice of standard appeal resolution within 30 calendar days of receipt of appeal request. Compliance was 50%. AGP should demonstrate consistent compliance in meeting the timeframe requirement for sending the enrollee a written appeal resolution within 30 calendar days of standard appeal receipt.	▲ A random sample record review provided evidence of AGP meeting the standard appeal resolution and notification requirement of 30 calendar days. Compliance was 100%.

2023 Recommendation	2024 Assessment
A random sample review found inconsistent compliance in sending written notice of an expedited appeal resolution within 72 hours of appeal receipt. Compliance was 71%. AGP should demonstrate consistent compliance in meeting the timeframe for providing the enrollee written notification of an expedited appeal resolution within 72 hours of receipt of the request.	No requests for expedited appeal were included in the sample. An assessment could not be conducted. The recommendation remains in place. AGP should ensure compliance in meeting the timeframe for providing the enrollee written notification of an expedited appeal resolution within 72 hours of receipt of the request.
A random sample review of appeal records found one extension was requested and was resolved within the extended timeframe. However, there was no evidence of a reasonable attempt to provide oral notice of the delay for the extension request. Compliance was 0% (based on one record). AGP should make (and document) a reasonable attempt to provide the enrollee with oral notice of the delay for any appeal extension requests.	No requests for an appeal resolution extension were included in the sample. An assessment could not be conducted. The recommendation remains in place. AGP should ensure it is making (and documenting) a reasonable attempt to provide the enrollee with oral notice of the delay for any appeal extension requests.
A random sample review of appeal records found inconsistencies in demonstrating compliance with the requirement for documenting a reasonable attempt to provide oral notice of an expedited appeal resolution. Compliance with a reasonable attempt to provide oral notice of an expedited appeal resolution was 43%. AGP should demonstrate consistent compliance with documenting a reasonable attempt to provide the enrollee oral notice of an expedited appeal resolution.	No requests for an expedited appeal were included in the sample. An assessment could not be conducted. The recommendation remains in place. AGP should ensure it is making and documenting a reasonable attempt to provide the enrollee oral notice of an expedited appeal resolution.
A random sample review of enrollee appeal resolution letters found inconsistent compliance with documentation of the date of the resolution. Compliance was 36%. AGP should consistently provide the date the resolution process was completed in all appeal resolution letters.	🟡 A random sample review found improvement in this measure. Compliance with including the date of the resolution process in the appeal resolution letters was 83%. This recommendation remains in place.
A random sample review of appeal resolution letters found inconsistent compliance in including the right to request continuation of benefits, where upholding the adverse benefit determination was the resolution. Compliance was 14%. AGP should include the right to request continuation of benefits and how to do so in appeal resolution letters.	🟢 A random sample record review provided evidence of AGP including the right to request continuation of benefits and how to do so in appeal resolution letters. Compliance was 100%.
NETWORK ADEQUACY VALIDATION	
Not applicable. The NAV task was conducted for the first time in 2024.	
ENCOUNTER DATA VALIDATION	
AGP was not required to participate in the 2023 EDV task due to its contract start date of April 1, 2023.	
NETWORK ADEQUACY SURVEY FOCUS STUDY	
AGP was not required to participate in the 2023 Network Adequacy Survey Focus Study due to its contract start date of April 1, 2023.	

HSCSN

HSCSN adequately addressed five (5) of 13 recommendations that could be re-evaluated, demonstrating a 38% compliance rating. There was one recommendation that could not be re-evaluated due to the absence of relevant records in the random samples drawn. This item will be re-evaluated during the next annual review. Table 67 provides details of the 2024 assessment.

Table 67. Assessment of HSCSN's Previous Annual Recommendations

2023 Recommendation	2024 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Behavioral Health PIP	
HSCSN did not include an aim statement that met all requirements. The MCP should amend its aim statement to clearly identify the population and provide an appropriate time period.	▲ HSCSN amended its aim statement and clearly specified the PIP's population and time period.
Childhood Obesity Management and Prevention PIP	
HSCSN did not demonstrate improvement was likely the result of selected improvement strategies, nor was any improvement statistically significant. HSCSN should conduct a more in-depth barrier analysis at the sub-measure level and use additional quality improvement tools to facilitate analysis. The MCP should achieve statistically significant improvement in at least one measure.	▼ HSCSN did not address the recommendations. The recommendations remain in place. The MCP should demonstrate reported improvement in performance is likely the result of the selected improvement strategies based upon analysis of data. This may include an assessment of the impact of each intervention on the performance measures selected. The MCP should also achieve statistically significant improvement in at least one measure.
PERFORMANCE MEASURE VALIDATION	
PIP and CMS Core Measure Performance Measures	
There were no formal 2023 recommendations for HSCSN.	
EPSDT Performance Measures	
There were no formal 2023 recommendations for HSCSN.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
There were no formal 2023 recommendations for HSCSN.	
Disenrollment Requirements and Limitations	
There were no formal 2023 recommendations for HSCSN.	
Enrollee Rights and Protections	
There were no formal 2023 recommendations for HSCSN.	
MCO Standards	
There were no formal 2023 recommendations for HSCSN.	
Quality Assessment and Performance Improvement Program	
There were no formal 2023 recommendations for HSCSN.	
Grievance and Appeal System	

2023 Recommendation	2024 Assessment
A random sample record review found inconsistent compliance with the two business day timeframe for sending the enrollee a grievance acknowledgment letter. Compliance was 89%. A random sample record review found inconsistent compliance with the two business day timeframe for sending the enrollee an appeal acknowledgment letter. Compliance was 83%. HSCSN should demonstrate consistent compliance with the timeframe requirements for sending enrollees written grievance and appeal acknowledgments (two business days).	🟡 A random sample review found some improvement in one of two measures. Compliance with sending timely grievances acknowledgement letters declined to 57%. Compliance with sending timely appeal acknowledgement letters improved to 91%. The recommendation remains in place to send enrollees written grievance and appeal acknowledgments within two business days.
HSCSN's policy on grievances does not specify that it ensures that individuals who make decisions on grievances are individuals who, if deciding a grievance involving a clinical issue, have the appropriate clinical expertise, as determined by DHCF, in treating the enrollee's condition or disease. HSCSN should revise its policy to include the requirement for individuals deciding a clinical issue, including denials of an expedited appeal resolution, have the appropriate clinical expertise in treating the condition or disease.	🟢 HSCSN amended its grievance policy to assert that it ensures that individuals who make decisions on grievances are individuals who, if deciding a grievance involving a clinical issue, have the appropriate clinical expertise, as determined by DHCF, in treating the enrollee's condition or disease.
A random sample record review found inconsistent compliance with the 90-day resolution notice timeframe requirement for grievances. Compliance was 94%. HSCSN should demonstrate consistent compliance with the standard grievance resolution notification timeframe requirement of 90 calendar days.	🔴 A random sample record review found a decline in compliance (67%) with standard grievance resolution notification. The recommendation remain in place. HSCSN should demonstrate consistent compliance with the standard grievance resolution notification timeframe requirement of 90 calendar days.
A random sample record review found inconsistent compliance with the 30 calendar day written resolution notice timeframe for standard appeals. Compliance was 79%. HSCSN should demonstrate consistent compliance in meeting the resolution notification timeframe of 30 calendar days from receipt of the standard appeal.	🔴 A random sample record review found a decline in compliance (58%) with standard appeal resolution notification. The recommendation remain in place. HSCSN should demonstrate consistent compliance in meeting the resolution notification timeframe of 30 calendar days from receipt of the standard appeal.

2023 Recommendation	2024 Assessment
HSCSN's policy on adverse benefit determination does not accurately reflect the expedited appeal regulation, which requires resolution and written notification within 72 hours of receipt of an expedited request. A random sample record review found inconsistent compliance with this standard. Compliance was 0% (based on only two expedited appeal records appearing in the sample). HSCSN should revise its policy to identify the timeframe for written notification of resolution of an expedited appeal as within 72 hours of receipt of the request. Additionally, HSCSN should demonstrate compliance with the written resolution notification timeframe of 72 hours from receipt of the request.	▲ HSCSN amended its policy on adverse benefit determinations to specify expedited appeal resolution and written notification must occur within 72 hours of receipt. A random sample record review demonstrated compliance (100%).
A random sample record review of appeal resolution letters provided evidence of compliance with the requirement to include the results of the resolution process and the date it was completed. However, not all records included a resolution letter. Compliance was 93%. HSCSN should consistently demonstrate that all appeal resolution letters include results of the resolution process and the date it was completed.	▼ A random sample record review found not all appeal records included resolution letters. Compliance was 91%. The recommendation remains in place. HSCSN should consistently demonstrate that all appeal resolution letters include results of the resolution process and the date it was completed.
A random sample record review found appeal resolution letters inconsistently included the right to request a fair hearing and continue benefits and how to make such requests, when appropriate. Compliance was 78%. HSCSN should include in all resolution letters (for appeals not resolved wholly in favor of the enrollee), the rights of the enrollee to request a fair hearing and continuation of benefits, and how to make such requests.	● A random sample review found some improvement in the measure. Compliance was 91%. The recommendation remains in place. HSCSN should include in all resolution letters (for appeals not resolved wholly in favor of the enrollee), the rights of the enrollee to request a fair hearing and continuation of benefits, and how to make such requests.
A random sample record review found no evidence of compliance with providing written notice of denial of a request for expedited appeal resolution and enrollee oral notification of the denial (0%). HSCSN should document in case notes the date the decision was made to deny the request for an expedited appeal resolution and a reasonable attempt to provide the enrollee with oral notice of the denied request for expedited resolution.	No denials of a request for expedited appeal resolution were included in the sample. An assessment could not be conducted. The recommendation remains in place. HSCSN should document in case notes the date the decision was made to deny the request for an expedited appeal resolution and a reasonable attempt to provide the enrollee with oral notice of the denied request for expedited resolution.
NETWORK ADEQUACY VALIDATION	
Not applicable. The NAV task was conducted for the first time in 2024.	
ENCOUNTER DATA VALIDATION	
There were no formal 2023 recommendations for HSCSN.	
NETWORK ADEQUACY SURVEY FOCUS STUDY	

2023 Recommendation	2024 Assessment
HSCSN received a score of 76% for timely access to adult routine appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.	▲ Compliance in obtaining timely adult routine appointments increased in MY 2024 (95%).
HSCSN received a score of 73% for timely access to adult urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.	● Compliance in obtaining timely adult urgent appointments increased (73% in MY 2023 to 85% in MY 2024). There continues to be opportunity to improve performance for adult urgent appointments.
HSCSN received a score of 60% for timely access to pediatric urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.	▲ Compliance in obtaining timely pediatric urgent appointments increased in MY 2024 (92%).
HSCSN received a score of 59% for overall provider directory accuracy. The MCP should make provider directory accuracy a priority and update information routinely.	▼ HSCSN's overall accuracy of its provider directory declined (59% in MY 2023 to 48% in MY 2024). The recommendation for improvement continues.

MFC

MFC adequately addressed four of eight recommendations that could be re-evaluated, demonstrating a 50% compliance rating. Table 68 provides details of the 2024 assessment.

Table 68. Assessment of MFC's Previous Annual Recommendations

2023 Recommendation	2024 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Behavioral Health PIP	
There were no formal 2023 recommendations for MFC.	
Maternal Health PIP	
MFC's aim statement did not meet all requirements and the MCP did not improve performance in the PIP measures. MFC should amend its aim statement to specify that it is aiming to improve the percentages of deliveries in which women had the recommended prenatal care and postpartum care visits. The MCP should also achieve improvement in at least one measure through implementation of continuous quality improvement strategies.	▲ MFC amended its PIP aim statement to meet all requirements. The MCP was not required to address the second recommendation since DHCF elected to "restart" the PIP with a new baseline (MY 2023).
PERFORMANCE MEASURE VALIDATION	
PIP and CMS Core Measure Performance Measures	
There were no formal 2023 recommendations for MFC.	
EPSDT Performance Measures	
There were no formal 2023 recommendations for MFC.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
There were no formal 2023 recommendations for MFC.	

2023 Recommendation	2024 Assessment
Disenrollment Requirements and Limitations	
There were no formal 2023 recommendations for MFC.	
Enrollee Rights and Protections	
MFC failed to produce a policy that ensures compliance with all federal and District laws. Specifically, compliance with Title IX of the Education Amendments of 1972 was omitted. MFC should assert compliance with all federal and District laws, including Title IX of the Education Amendments of 1972.	▲ MFC amended a relevant policy and included reference to Title IX of the Education Amendments of 1972.
MCO Standards	
MFC contracted with a new delegate and the Master Services Agreement did not include all requirements for oversight audits. MFC should amend its agreement and include all oversight audit components required by federal regulations.	▲ MFC amended their agreement with their delegate and included all oversight audit components required by federal regulations.
Quality Assessment and Performance Improvement Program	
There were no formal 2023 recommendations for MFC.	
Grievance and Appeal System	
A random sample record review found inconsistent compliance with the two business day timeframe for sending the enrollee a grievance acknowledgment letter. Compliance was 93%. A random sample record review found inconsistent compliance with the two business day timeframe for sending the enrollee an appeal acknowledgment letter. Compliance was 97%. MFC should demonstrate consistent compliance with the timeframe requirements for sending enrollees written grievance and appeal acknowledgments (two business days).	▲ A random sample record review found MFC demonstrated 100% compliance with sending enrollees written grievance and appeal acknowledgments within two business days.
NETWORK ADEQUACY VALIDATION	
Not applicable. The NAV task was conducted for the first time in 2024.	
ENCOUNTER DATA VALIDATION	
MFC scored 82.0% in the 2023 encounter data validation study. Most “no match” reasons were attributed to a lack of supporting documentation in the medical record. MFC should educate its providers on including sufficient documentation in the medical records to support codes for billed claims.	● MFC scored 92.8% in the 2024 encounter data validation study. While performance improved compared to the previous annual rate, there continues to be opportunity for improvement. This recommendation remains in place.
NETWORK ADEQUACY SURVEY FOCUS STUDY	
MFC received a score of 64% for timely access to adult urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.	● Compliance in obtaining timely adult urgent appointments increased (64% in MY 2023 to 81% in MY 2024). There continues to be opportunity to improve performance for adult urgent appointments.

2023 Recommendation	2024 Assessment
MFC received a score of 76% for timely access to pediatric urgent appointments. The MCP should follow up with noncompliant providers, provide education, and require corrective actions, as necessary in order to improve timely access.	🟡 Compliance in obtaining timely pediatric urgent appointments increased (76% in MY 2023 to 77% in MY 2024). There continues to be opportunity to improve performance for pediatric urgent appointments.
MFC received a score of 58% for overall provider directory accuracy. The MCP should make provider directory accuracy a priority and update information routinely.	🔴 MFC's overall accuracy of its provider directory declined significantly (58% in MY 2023 to 11% in MY 2024). The recommendation for improvement continues.

UHC

UHC adequately addressed 12 of 15 recommendations that could be re-evaluated, demonstrating a 80% compliance rating. Table 69 provides details of the 2024 assessment.

Table 69. Assessment of UHC's Previous Annual Recommendations

2023 Recommendation	2024 Assessment
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	
Behavioral Health PIP	
UHC's aim statement did not clearly specify the population. The MCP should amend its aim statement and clearly specify the population targeted by the PIP.	🟢 UHC amended its aim statement and clearly specified the PIP's population.
Fall Risk Management PIP	
There were no formal 2023 recommendations for UHC.	
PERFORMANCE MEASURE VALIDATION	
PIP and CMS Core Measure Performance Measures	
There were no formal 2023 recommendations for UHC.	
OPERATIONAL SYSTEMS REVIEW	
Information Requirements	
There were no formal 2023 recommendations for UHC.	
Disenrollment Requirements and Limitations	
There were no formal 2023 recommendations for UHC.	
Enrollee Rights and Protections	
UHC's enrollee rights policy does not explicitly state the enrollee right to refuse treatment. UHC should amend its enrollee rights policy and explicitly state the enrollee right to refuse treatment.	🟢 UHC amended its enrollee rights policy. The policy asserts the enrollee right to refuse treatment.

2023 Recommendation	2024 Assessment
UHC's enrollee rights policy does not explicitly state the enrollee right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. UHC should amend its enrollee rights policy and explicitly state the enrollee right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.	▲ UHC amended its enrollee rights policy. The policy asserts the enrollee right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
UHC's enrollee rights policy does not explicitly state the enrollee right to request and receive a copy of his or her medical records, and request that they be amended or corrected. UHC should amend its enrollee rights policy and explicitly state the enrollee's right to request and receive a copy of his or her medical records, and request that they be amended or corrected.	▲ UHC amended its enrollee rights policy. The policy asserts the enrollee right to request and receive a copy of his or her medical records, and request that they be amended or corrected.
UHC's enrollee rights policy does not explicitly state the enrollee has the right to be furnished health care services in accordance with §§438.206 through 438.210. UHC should amend its enrollee rights policy and explicitly state the enrollee has the right to be furnished health care services in accordance with §§438.206 through 438.210. These standards cover enrollee access and availability to services, coordination of care, and authorization of services.	▲ UHC amended its enrollee rights policy. The policy asserts the enrollee has the right to be furnished health care services in accordance with §§438.206 through 438.210.
UHC's enrollee rights policy does not explicitly state the enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCP and its network providers or the State agency treat the enrollee. UHC should amend its enrollee rights policy and explicitly state the enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCP and its network providers or the State agency treat the enrollee.	▲ UHC amended its enrollee rights policy. The policy asserts the enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCP and its network providers or the State agency treat the enrollee.
UHC's non-discrimination policy does not explicitly state its compliance with Title IX of the Education Amendments of 1972 and Titles II and III of the Americans with Disabilities Act. UHC should amend its non-discrimination policy and explicitly state its compliance with Title IX of the Education Amendments of 1972 and Titles II and III of the Americans with Disabilities Act.	▲ UHC amended its non-discrimination policy and asserts its compliance with Title IX of the Education Amendments of 1972 and Titles II and III of the Americans with Disabilities Act.

2023 Recommendation	2024 Assessment
UHC's enrollee rights policy does not explicitly state the MCP may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient. UHC should amend its enrollee rights policy and explicitly state the MCP may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: (i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. (ii) Any information the enrollee needs to decide among all relevant treatment options. (iii) The risks, benefits, and consequences of treatment or non-treatment. (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	▲ UHC amended its enrollee rights policy and asserts the MCP may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: (i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. (ii) Any information the enrollee needs to decide among all relevant treatment options. (iii) The risks, benefits, and consequences of treatment or non-treatment. (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
MCO Standards	
UHC did not produce a policy that specified that UHC must submit documentation to DHCF that provides evidence of a provider network that demonstrates adequate availability of services and assurance of adequate capacity and services. UHC should document (in a policy) that it maintains an adequate network of providers (according to DHCF's contract requirements) and it submits evidence at the time it enters into a contract with the District; on an annual basis; at any time there has been a significant change (as defined by the District) in the MCP's operations that would affect the adequacy of capacity and services, including: changes in MCP services, benefits, geographic service area, composition of or payments to its provider network; or enrollment of a new population in the MCP.	▲ UHC amended a network access policy and asserted the MCP maintains an adequate network of providers (according to DHCF's contract requirements) and it submits evidence at the time it enters into a contract with the District; on an annual basis; at any time there has been a significant change (as defined by the District) in the MCP's operations that would affect the adequacy of capacity and services, including: changes in MCP services, benefits, geographic service area, composition of or payments to its provider network; or enrollment of a new population in the MCP.
Quality Assessment and Performance Improvement Program	
There were no formal 2023 recommendations for UHC.	
Grievance and Appeal System	
A random sample review of adverse benefit determination records found inconsistent compliance on providing information on how to request continuation of benefits. Compliance was 50%. UHC should demonstrate consistent compliance in providing information on how to request continuation of benefits in its notices of adverse benefit determinations.	▲ A random sample review of adverse benefit determination records found consistent compliance on providing information on how to request continuation of benefits. Compliance was 100%.

2023 Recommendation	2024 Assessment
A random sample record review found inconsistent compliance with the two business day timeframe for sending the enrollee a grievance acknowledgment letter. Compliance was 3%. A random sample record review found inconsistent compliance with the two business day timeframe for sending the enrollee an appeal acknowledgment letter. Compliance was 3%. UHC should demonstrate consistent compliance with the timeframe requirements for sending enrollees written grievance and appeal acknowledgments (two business days).	🟡 A random sample review found some improvement in both measures. Compliance with sending timely grievances acknowledgement letters improved to 63%. Compliance with sending timely appeal acknowledgement letters improved to 40%. The recommendation remains in place to send enrollees written grievance and appeal acknowledgments within two business days.
A random sample review of expedited appeal records found inconsistent compliance on meeting the 72-hour resolution and notice timeframe. Compliance was 78%. UHC should demonstrate consistent compliance with the 72-hour timeframe for expedited appeal resolutions, inclusive of written notifications.	🟢 A random sample review of expedited appeal records found consistent compliance with the 72-hour timeframe for expedited appeal resolutions, inclusive of written notifications. Compliance was 100%.
A random sample review of appeal records found inconsistent compliance in documenting the date the resolution was completed within the resolution letters to enrollees. Compliance was 3%. It was also determined that when someone, such as a provider, filed an appeal on the enrollee's behalf, UHC copied the enrollee on the resolution letter, rather than sending them the letter directly. UHC should demonstrate consistent compliance with documenting the date the resolution was completed within the resolution letters to enrollees. Additionally, if an individual files on behalf of the enrollee, the resolution letter should be addressed to the enrollee and the individual filing the appeal should be copied.	🟡 A random sample review found some improvement. Compliance with including the date the appeal resolution was completed in the appeal resolution letters improved to 67%. Compliance with including the enrollee's name in the resolution letter salutation (rather than the provider) was 53%. The recommendation remains in place. UHC should demonstrate consistent compliance with documenting the date the resolution was completed within the resolution letters to enrollees. Additionally, if an individual files on behalf of the enrollee, the resolution letter should be addressed to the enrollee and the individual filing the appeal should be copied.
Dual-Eligible Special Needs Plan	
A random sample review of grievance and appeal records demonstrated inconsistent use of approved templates. UHC should demonstrate consistent use of CMS-approved letter templates for grievance and appeal resolution notices.	🟢 UHC provided evidence of CMS-approved Appeal Decision and Fast Complaint letter templates on UHC letterhead to support compliance.
NETWORK ADEQUACY VALIDATION	
Not applicable. The NAV task was conducted for the first time in 2024.	
ENCOUNTER DATA VALIDATION	
This task is not required for UHC.	
NETWORK ADEQUACY SURVEY FOCUS STUDY	

2023 Recommendation	2024 Assessment
UHC received an 88% compliance rating in the Provider Directory Phone Number Match measure for LTSS providers. UHC should routinely survey all LTSS providers to ensure contact information is up-to-date and accurate.	🟡 UHC demonstrated some improvement (88% to 89%). This recommendation to ensure contact information is current and accurate remains in place.

State Recommendations

Quality Strategy Goals

DHCF continuously strives to improve the health and well-being of the District's residents. DHCF's mission focuses on improving health outcomes by providing access to comprehensive, cost-effective, and quality health care services. To provide a means for achieving this mission, DHCF drafted its *Medicaid Managed Care Quality Strategy*, effective 2024-2027.¹⁷

Table 70 identifies the current quality strategy goals and objectives. Most notably, DHCF introduced objectives that include specific measures and performance targets. These identified targets provide DHCF with the opportunity to measure MCP performance and identify specific gaps, and where MCPs met or exceeded expectations. Some targets are currently specified as to be determined (TBD); in these instances, DHCF aims to specify targets after in the future based on baseline performance.

Table 70. DHCF Quality Strategy Goals, 2024-2027

Quadruple Aim Pillar	DHCF Goals	Objectives
BETTER CARE Improving the patient experience of care	1. Ensure access to quality, whole-person care	- Improve CAHPS performance in the Rating of Health Plan measure (target TBD) - Improve CAHPS performance in the Rating of Personal Doctor measure (target TBD) - Improve the health plan rate of contacting enrollees within 48 hours of an emergency department visit (target TBD) - Achieve NCQA Case Management Accreditation status (DCHFP and CASSIP MCPs) - Improve the percentage of sharing specialty visit notes with PCPs within 60 days of visit (target TBD) - Ensure the Hospital Emergency Department Utilization Report captures the percentage of MCP follow-up within 48 hours of an enrollee emergency department or inpatient admission (target TBD) - Improve the percentage of behavioral health provider referrals from PCPs for enrollees with an initial behavioral health diagnosis (target TBD) - Increase the percentage of enrollees with a behavioral health visit within 30 days following diagnosis of a behavioral health condition by PCP (target TBD)

¹⁷ [District of Columbia Medicaid Managed Care Quality Strategy, 2024-2027](#)

Quadruple Aim Pillar	DHCF Goals	Objectives
		• Increase the percentage of enrollees turning 21 years old within the MY who had a visit with an adult PCP (target TBD) • Increase the MCP average HEDIS rate for Controlling High Blood Pressure by 3% • Increase the MCP average HEDIS rate for Diabetes Screening for Enrollees with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication by 3%
HEALTHY PEOPLE, HEALTHY COMMUNITY Improving the health of District residents	2. Improve management of chronic conditions	• Increase the MCP average HEDIS rates by three percentage points for the following measures: ○ Adherence to Antipsychotic Medications for Individuals with Schizophrenia ○ Follow-up After an Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days and Within 30 Days ○ Follow-up After an Emergency Department Visit for Mental Illness Within 7 Days and Within 30 Days • Increase the MCP average HEDIS rates by three percent for the following measures: ○ Hemoglobin A1c (HbA1c) Control for Patients with Diabetes ○ Eye Exam (retinal) for Patients with Diabetes ○ Statin Therapy for Patients with Diabetes: (1) Received Statin Therapy and (2) Statin Therapy Adherence 80% ○ Kidney Health Evaluation for Patients with Diabetes ○ Blood Pressure Control for Patients with Diabetes ○ Controlling High Blood Pressure
	3. Improve population health	• Increase the MCP average HEDIS rates by three percent for the following measures: ○ Timeliness of Prenatal Care ○ Postpartum Care ○ Contraceptive Care for All Women ○ Contraceptive Care for Postpartum Women • Increase the MCP average HEDIS rates by three percentage points for all age categories for the number of children and adolescents who received a well-child visit • Increase the MCP average HEDIS rates by three percent for all age categories for the number of children who received a well-child visit in the first 30 months of life • Reduce health disparities (target TBD) by closing the performance gaps in at least one demographic factor

Quadruple Aim Pillar	DHCF Goals	Objectives
		(age, race/ethnicity, primary language, gender, or disability status) for following HEDIS measures: ○ Child and Adolescent Well-Care Visits ○ Asthma Medication Ratio ○ Prenatal and Postpartum Care ○ Follow-Up After Hospitalization for Mental Illness • For the DDCP: ○ Increase the percentage of LTSS members with an LTSS Comprehensive Assessment and Update (MLTSS-1) (target TBD) ○ Increase the percentage of LTSS members with an LTSS Comprehensive Care Plan and Update (MLTSS-2) (target TBD) ○ Increase the percentage of LTSS members with an LTSS Reassessment/Care Plan Update after Discharge (MLTSS-4) (target TBD) ○ Increase the MCP average HEDIS rates for the following Social Need Screening and Intervention measures by three percent (Test Measure): ▪ Food Screening and Intervention ▪ Housing Screening and Intervention ▪ Transportation Screening and Intervention
PAY FOR VALUE Reducing the cost of health care	4. Ensure high-value, appropriate care	• For the DCHFP: ○ Increase the percentage of total medical expenditures included in the VBP program administered by MCP (2024 baseline: 30%, 2025: 40%, 2026: 50%, and 2027: 60%) ○ Demonstrate improvement in the following P4P quality measures: ▪ Potentially Preventable Admissions (target TBD) ▪ Low Acuity Non-Emergent (target TBD) ▪ Plan All-Cause Readmissions (target TBD) • Ensure all providers participating in VBP or P4P initiatives work with the District's designated Health Information Exchange (HIE) entity and become credentialed to use the HIE's PopHealth Analytics tool (target: 100%)

Quadruple Aim Pillar	DHCF Goals	Objectives
PROVIDER SATISFACTION Assessing and prioritizing the District's clinician experience	5. Improve clinician experience	- Improve the MCP average rating for the following focus areas: - Satisfaction with Health Plan (target TBD) - Satisfaction with Utilization Management (target TBD) - Satisfaction with Claims (target TBD) - Maintain or exceed compliance of clean claims processing within 90 days (2025 target: 99%)

Evaluating and Holding MCPs Accountable for Quality Performance

DHCF evaluates MCP progress in meeting Quality Strategy goals through:

- Quality and appropriateness of care assessments
- National performance measures
- Monitoring and compliance
- EQR activities

DHCF holds MCPs accountable through procedures outlined in its *Managed Care Program Quality Management Manual*. The manual describes MCP performance expectations and required follow-up corrective actions. Based on performance, and whether the occurrence is first time or repeated, DHCF may issue a non-compliance warning letter, require a CAP or enhanced monitoring, and/or sanction the noncompliant MCP. As demonstrated in Tables 65-69, which evaluated compliance with previous annual recommendations, this strategy has largely proven its effectiveness, as MCPs have fully addressed or at least demonstrated improvement in most areas requiring intervention.

DHCF requires the DCHFP and CASSIP MCPs participate in a pay for performance (P4P) program and coordinate care. The MCPs are expected to advance their enrollees' health care and improve outcomes per dollar spent through aggressive care coordination and health care management. The MCPs must meet performance goals in order to receive their full capitated payment rate; a percentage withhold is used to fund the program when goals are met. DHCF uses the following metrics to assess MCP efforts to coordinate enrollee care:

- *Low Acuity Non-emergent Visits*. Reduce emergency room utilization for non-emergency conditions.
- *Potentially Preventable Admissions*. Reduce hospital admissions that could have been avoided with access to quality primary and preventive care.
- *30-Day All-Cause Readmissions*. Reduce hospital readmissions for problems related to the diagnosis that prompted a previous and recent (within 30 days) hospitalization.

DHCF expects DCHFP MCPs to engage in value-based purchasing (VBP) arrangements or other alternative payment methodologies with their network providers. This initiative rewards providers for performance excellence and performance improvement in targeted priority areas, which aim to improve enrollee health outcomes and/or provide cost savings to the health system.

DHCF has also developed a Managed Care Program Accountability Set, which uses select industry-standard quality performance measures to hold MCPs accountable for their performance and to drive quality improvement. This program includes:

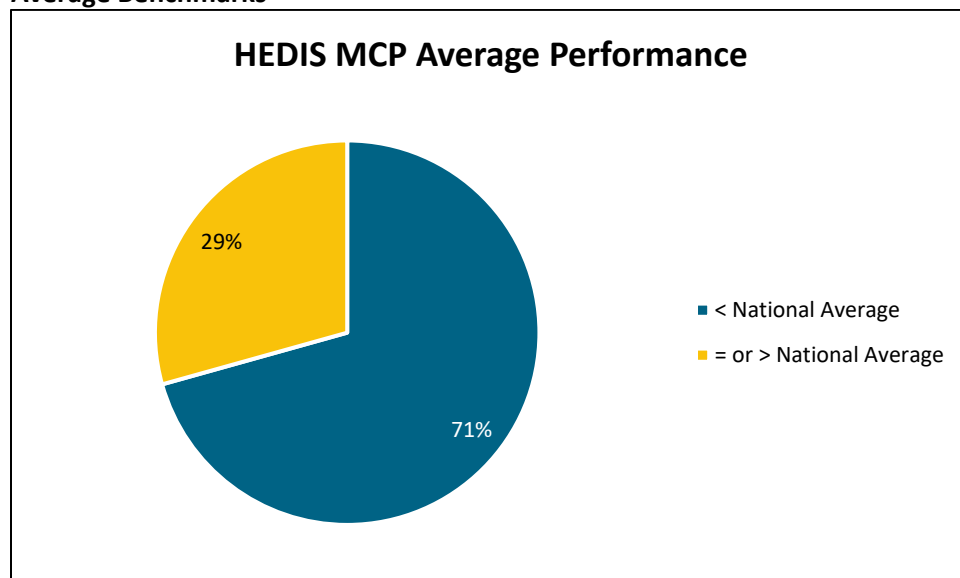
- A defined set of standardized performance measures for which MCPs are held accountable. Measures include: select CMS Adult Core Set measures and all CMS Child and Behavioral Health Core Set measures.
- Reasonable and achievable performance benchmarks.
- Well-defined criteria for compliance actions when quality improvement benchmarks are not met, such as sanctions, CAPs, and financial withholds.
- Criteria for rewards, such as withhold payouts and auto-assignment preferences.

Recommendations on How DHCF Can Target Quality Strategy Goals and Objectives

The intent of the *Medicaid Managed Care Quality Strategy* is to provide an overarching framework for DHCF to drive quality and performance improvement among its contracted MCPs, with the ultimate goal of improving health outcomes for its enrollees. While MCPs are committed to quality and have developed strategies to demonstrate improvement, they are all in a position in which there is an opportunity to close gaps in care and quality. An analysis of HEDIS and CAHPS survey measures, included in Appendix A1 and A2, respectively, demonstrate MCP averages fall short of meeting national average benchmarks in many measures relating to the effectiveness of care, access, and availability of services, preventive care utilization, and enrollee experience of care.

Figure 23 illustrates how DC MCP averages compared to national average benchmarks for HEDIS measures identified in Appendix A1.

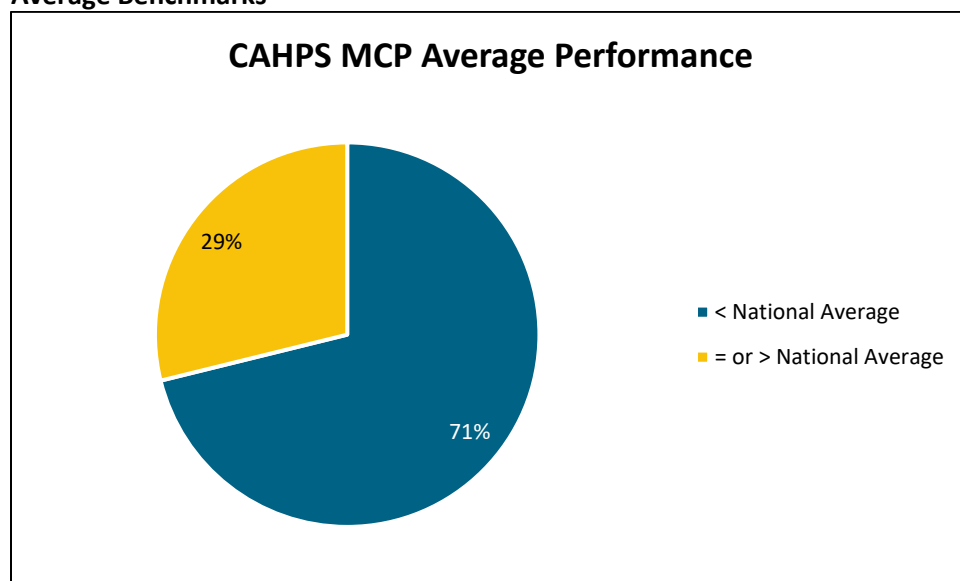
Figure 23. MY 2023 HEDIS MCP Average Performance Compared to National Average Benchmarks



The DC MCP averages performed better than national average benchmarks in 29% of the HEDIS measures. Last year this rate was 32%. This area continues as an opportunity for improvement. **Qlarant recommends** DHCF continue to encourage MCP improvements and hold them accountable for HEDIS measure performance. Identifying specific measures in the Quality Strategy helps MCPs focus and concentrate resources on measures that are meaningful to DHCF.

Figure 24 illustrates how DC MCP averages compared to national average benchmarks for CAHPS measures identified in Appendix A2.

Figure 24. MY 2023 CAHPS MCP Average Performance Compared to National Average Benchmarks



The DC MCP averages performed better than national average benchmarks in 29% of the CAHPS measures. Last year this rate was 36%. This area continues as an opportunity for improvement. DHCF identifies specific CAHPS measure objectives within the latest Quality Strategy. **Qlarant recommends** DHCF continue to encourage MCP improvements and hold them accountable for CAHPS measure performance. Defined measures provide opportunity for MCPs to concentrate on experience of care activities that are priority to DHCF.

Qlarant makes additional recommendations below for DHCF to consider. Recommendations describe how DHCF can target Quality Strategy goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services furnished to DC managed care enrollees.

The MCPs are required to conduct an initial screening of each enrollee's physical, behavioral, and social needs upon enrollment. Barriers exist to obtaining this critical information from enrollees, which can negatively impact care coordination and management. **Qlarant recommends** DHCF establish targets for the MCPs to complete initial screenings within 30, 60, and 90 days. MCPs should make multiple attempts to obtain and complete these screenings, which provide valuable information, including identification of risk factors, such as social determinants of health (SDoH), chronic conditions, substance use, mental health disorders, and other health and safety issues. If MCPs improve compliance in completing these screenings, they can potentially achieve improvements related to Goals 1-3 by

ensuring access to quality, whole-person care; improving the management of chronic conditions; and improving population health.

DHCF has encouraged MCPs to address enrollee social needs consistent with CMS guidance. Social, environmental, and economic factors can influence health status. *Qlarant recommends* DHCF continue to prioritize initiatives that may address SDoH. For example, DHCF's adoption of a value-based purchasing program incentivizes MCPs to address SDoH, as well as disparities across the health care system. In alignment with DHCF's aim of *Healthy People, Healthy Community*, prioritizing this incentive may assist in reducing costs and advancing value-based care within the District. MCPs should develop interventions that address barriers to food and housing security, as well as transportation. Especially important for the DDCP D-SNP, an investment in interventions may prevent or delay enrollees from needing nursing facility care.

The MCPs are required to resolve, track, and report enrollee grievances. The MCPs should be addressing barriers and improving enrollee experiences. *Qlarant recommends* DHCF develop, or have Qlarant develop, a focus study on enrollee grievances that aggregates and analyzes MCP grievances. The study should identify trends, barriers, and actions to improve performance. This will provide DHCF with additional insight into enrollee grievances and support the Quality Strategy's goal of improving the patient experience of care.

DHCF specifies network adequacy standards in the MCP contracts. In some instances general parameters are included, rather than explicit requirements. *Qlarant recommends* DHCF include a table in the MCP contracts, which explicitly identifies each network capacity and geographic accessibility requirement, and each specific provider type required to meet the standards. This will assist the MCPs in identifying all provider types to include in their Provider Network Reports. This clarification has the potential to positively impact performance related to the Quality Strategy's goal of ensuring access to quality, whole-person care as provider network assessments will be comprehensive and provide a complete picture of enrollee access.

DHCF is implementing a Managed Care Program Accountability Set program to hold MCPs responsible for their performance and encourage improvements. *Qlarant recommends* DHCF leverage EQRO expertise in selecting and maintaining meaningful measures, identifying reasonable targets, and conducting an analysis of results. This accountability program has the potential to positively impact performance related to multiple Quality Strategy goals.

Confidence levels in MCP compliance have been established for most EQR tasks, including PIP validation, PMV, OSR, and most recently NAV and EDV. For example, an MCP scoring between 95%-100% in the OSR task is assigned a high confidence level, meaning stakeholders can have high confidence in the MCP's level of compliance with structural and operational standards. Levels of confidence have not been established for the Network Adequacy Survey Focus Study. *Qlarant recommends* DHCF work with the EQRO to establish confidence levels for this activity, which evaluates MCP compliance with network adequacy standards and the accuracy of their provider directories. All EQR tasks should have clear thresholds to assist MCPs in driving process improvement and DHCF in holding them accountable. This recommendation indirectly supports all DHCF Quality Strategy goals, as MCPs strive for improvements and full compliance with standards established by DHCF.

DHCF is holding MCPs accountable, as previously described, by way of procedures outlined in its *Managed Care Program Quality Management Manual*. This strategy appears to make an impact. The

2024 EQR activities found MCPs fully addressed the majority of recommendations made in 2023—ACDC: 71%, AGP: 78%, HSCSN: 38%, MFC: 50%, and UHC: 80%. **Qlarant recommends** DHCF continue to hold MCPs responsible for performance and require corrective actions. These improvements influence performance related to quality of and access to health care services.

MCP provider directories continue to have high rates of inaccurate provider contact information.

Qlarant recommends DHCF emphasize the importance of accurate provider information. Enrollees rely on this information when selecting providers to establish care or obtain health care services. Inaccurate information presents as a barrier and can be frustrating to an enrollee attempting to seek services. Improvements may assist in an easier process to schedule care and result in a higher rate of enrollee satisfaction. Areas or indicators requiring the most attention and opportunity include “Provider is with Practice and Provides the Desired Service” and “Provider Accepts Listed Insurance.”

Conclusion

As the District’s contracted EQRO, Qlarant evaluated DHCF’s managed care programs, including DCHFP, CASSIP, and DDCP, to assess compliance with federal and DC-specific requirements. Review and validation activities occurred over the course of 2024 and assessed MY 2023 and MY 2024 performance, as applicable. Qlarant evaluated each participating MCP and found:

- All MCPs participated in a new Behavioral Health PIP and reported baseline performance, as applicable. The overall average MCP PIP validation score was 97.1%. High confidence was assessed for all MCPs, except for AGP in which moderate confidence was assessed.
- The DCHFP MCPs reported baseline results for the Maternal Health PIP, as applicable. The overall average MCP PIP validation score was 98.2%. High confidence was assessed for all MCPs.
- The CASSIP MCP reported its second remeasurement results for the Childhood Obesity Management and Prevention PIP. HSCSN reported mixed results for the PIP measures and received a moderate confidence validation rating.
- The DDCP D-SNP reported its first remeasurement results for the Fall Risk Management PIP. The MCP reported statistically significant improvement in two of three measures (Falls Risk Screening and Plan of Care) and received a high confidence rating.
- All MCPs had appropriate systems in place to process accurate claims and encounters. All MCPs received “reportable” designations for the calculation of PIP, CMS Core Set measures, and EPSDT measures, as applicable.
- MCPs had operational systems, policies, and staff in place to support core processes necessary to deliver services to enrollees. The overall OSR score was 98.58%. All MCPs achieved high confidence ratings. All MCPs were required to complete at least one CAP. Most frequently, CAPs were required for the Grievance and Appeal System Standard.
- Overall, stakeholders can have high confidence in each MCP’s Provider Network Report, which includes network capacity and geographic accessibility indicator compliance with DHCF established provider network standards. The assessment evaluates each MCP’s data collection procedures, methods of analysis, and interpretation of results. All MCPs received a high compliance rating for each indicator they reported, with one exception: MFC received a moderate confidence rating in their pharmacy indicator in regard to geographic accessibility.
- A medical record review for the EDV activity yielded a 94.5% overall encounter data accuracy rate. This is a 4.7 percentage point improvement over the previous annual MCP average of 89.8%; this improvement ended the negative trend in performance.

- MCPs have robust PCP networks demonstrating compliance with geographic and provider-to-enrollee requirements, as applicable. DCHFP and CASSIP MCP adult and pediatric PCP access for routine and urgent care survey results demonstrate compliance ratings ranging from 77%-100% for 2024. Access to all appointment types improved, based on MCP averages, during MY 2024. Overall accuracy of MCP online provider directories declined after a significant improvement in MY 2023. Most frequently, provider directory inaccuracy was attributed to the surveyed providers not participating with the identified practice or providing the desired services. The DDCP D-SNP was compliant with meeting the minimum number of providers for all LTSS types, as required by DHCF. UHC demonstrated a provider directory accuracy rate of 65% for LTSS provider listings. The DDCP D-SNP enrollees have access to home health agency covered services within 72 hours of acceptance of a referral.
- All MCPs demonstrated strengths and weaknesses in the areas of quality, access, and timeliness. MCPs should address specific recommendations made to improve performance in these areas.
- The MCPs adequately addressed most, but not all, of their previous annual recommendations. MCPs should focus efforts on addressing all recommendations to demonstrate improvements in quality, access, and timeliness.
- DHCF continues to strive to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services through its managed care programs. DHCF's *Medicaid Managed Care Quality Strategy* provides a framework to achieve improvements and ensure access to quality, whole-person care; improve management of chronic conditions; improve population health; and ensure high-value, appropriate care.
- DHCF should consider implementing Qlarant's recommendations, which if acted upon, may improve processes and close gaps in care and quality. Recommendations describe how DHCF can target Quality Strategy goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services furnished to DC managed care enrollees.

Appendix 1 - HEDIS® Measures Collected and Reported to NCQA

The table below includes 2024, measurement year (MY) 2023, Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure results for each District of Columbia managed care plan (MCP) and a comparison to the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO benchmarks. The MCP average is compared to benchmarks using a diamond rating system as defined below.

- ◆◆◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass 90th Percentile
- ◆◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile
- ◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile
- ◆ MCP rate is below the NCQA Quality Compass National Average

Table 1. Appendix 1 – HEDIS Performance Measures

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Total)	78.89	--	NA	78.33	36.36	64.53	◆ ◆
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (18-64 Yrs)	47.53	--	NA	53.7	NA	50.62	◆ ◆ ◆
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (3 months-17 Yrs)	91.52	--	NA	91.12	NA	91.32	◆ ◆ ◆ ◆
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (65+ Yrs)	NA	--	NA	NA	36.36	36.36	◆
AAP	Adults' Access to Preventive/ Ambulatory Health Services (20-44 Yrs)	66.01	--	75.74	47.57	92.88	70.55	◆
AAP	Adults' Access to Preventive/ Ambulatory Health Services (45-64 Yrs)	76.52	--	NA	60.81	97.08	78.14	◆
AAP	Adults' Access to Preventive/ Ambulatory Health Services (65+ Yrs)	75.6	--	NA	61.33	97.29	78.07	◆
AAP	Adults' Access to Preventive/ Ambulatory Health Services (Total)	69.7	--	75.74	52.19	97.14	73.69	◆
ADD/ ADD-E	Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	44.12	--	NA	NA	NA	44.12	◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
ADD/ ADD-E	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	31.02	--	41.56	0	NA	24.19	◆
AMB	Ambulatory Care - Emergency Dept Visits/1000 MM (Total)	616.17	--	782.24	502.46	906.96	701.96	◆ ◆ ◆
AMB	Ambulatory Care - Outpatient Visits/1000 MM (Total)	3473.99	--	3293	2452	12272	5373	◆ ◆ ◆
AMM	Antidepressant Medication Management - Effective Acute Phase Treatment	49.7	--	NA	57.37	70.49	59.19	◆
AMM	Antidepressant Medication Management - Effective Continuation Phase Treatment	30.57	--	NA	38.61	56.6	41.93	◆
AMR	Asthma Medication Ratio (12-18 Yrs)	45.42	--	51.47	38.61	NA	45.17	◆
AMR	Asthma Medication Ratio (19-50 Yrs)	47.97	--	NA	53.33	NA	50.65	◆
AMR	Asthma Medication Ratio (5-11 Yrs)	33.22	--	60	35.53	NA	42.92	◆
AMR	Asthma Medication Ratio (51-64 Yrs)	50.84	--	NA	44.53	51.16	48.84	◆
AMR	Asthma Medication Ratio (Total)	45.23	--	58.28	44.96	54.95	50.86	◆
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17 Yrs)	32.35	--	30.34	2.63	NA	21.77	◆
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	29.41	--	28.7	4.92	NA	21.01	◆
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)	46.08	--	45.22	24.59	NA	38.63	◆
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11 Yrs)	26.47	--	NA	NA	NA	26.47	◆
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17 Yrs)	55.88	--	49.44	31.58	NA	45.63	◆
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11 Yrs)	23.53	--	NA	NA	NA	23.53	◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)	32.35	--	31.3	6.56	NA	23.40	◆
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11 Yrs)	23.53	--	NA	NA	NA	23.53	◆
APM/ APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17 Yrs)	36.76	--	31.46	2.63	NA	23.62	◆
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 Yrs)	36.11	--	NA	NA	NA	36.11	◆
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	34.33	--	32.26	20.51	NA	29.03	◆
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11 Yrs)	32.26	--	NA	NA	NA	32.26	◆
BCS/B CS-E	Breast Cancer Screening	55.98	--	NQ	43.8	75.64	58.47	◆ ◆
BPD	Blood Pressure Control for Patients With Diabetes	53.28	--	69.44	59.61	73.72	64.01	◆
CBP	Controlling High Blood Pressure	49.88	--	NA	47.45	72.02	56.45	◆
CCS/C CS-E	Cervical Cancer Screening	58.61	--	62.12	40.63	49.64	52.75	◆
CHL	Chlamydia Screening in Women (16-20 Yrs)	79.42	--	73.02	74.53	NA	75.66	◆ ◆ ◆ ◆
CHL	Chlamydia Screening in Women (21-24 Yrs)	78.85	--	70.31	75.37	NA	74.84	◆ ◆ ◆ ◆
CHL	Chlamydia Screening in Women (Total)	79.18	--	72.01	74.91	NA	75.37	◆ ◆ ◆ ◆
CIS	Childhood Immunization Status - Pneumococcal Conjugate	66.18	--	75.51	54.01	NA	65.23	◆
CIS	Childhood Immunization Status - Combination 10	24.82	--	14.29	18.98	NA	19.36	◆
CIS	Childhood Immunization Status - Combination 3	58.88	--	61.22	48.18	NA	56.09	◆
CIS	Childhood Immunization Status - Combination 7	51.34	--	32.65	38.44	NA	40.81	◆
CIS	Childhood Immunization Status - DTaP	64.72	--	73.47	54.26	NA	64.15	◆
CIS	Childhood Immunization Status - HiB	81.02	--	83.67	70.07	NA	78.25	◆
CIS	Childhood Immunization Status - Hepatitis A	81.51	--	83.67	72.51	NA	79.23	◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
CIS	Childhood Immunization Status - Hepatitis B	75.91	--	79.59	69.59	NA	75.03	◆
CIS	Childhood Immunization Status - IPV	80.29	--	83.67	69.34	NA	77.77	◆
CIS	Childhood Immunization Status - Influenza	30.9	--	46.94	29.44	NA	35.76	◆
CIS	Childhood Immunization Status - MMR	83.7	--	85.71	73.97	NA	81.13	◆
CIS	Childhood Immunization Status - Rotavirus	61.56	--	48.98	46.72	NA	52.42	◆
CIS	Childhood Immunization Status - VZV	84.18	--	85.71	74.45	NA	81.45	◆
COU	Risk of Continued Opioid Use >= 15 Days (18-64 Yrs)	3.19	--	0	2.53	9.32	3.76	NC
COU	Risk of Continued Opioid Use >= 15 Days (65 Yrs)	NA	--	NA	NA	9.69	9.69	NC
COU	Risk of Continued Opioid Use >= 15 Days (Total)	3.2	--	0	2.54	9.57	3.83	NC
COU	Risk of Continued Opioid Use >= 30 Days (18-64 Yrs)	1.9	--	0	1.17	4.9	1.99	NC
COU	Risk of Continued Opioid Use >= 30 Days (65 Yrs)	NA	--	NA	NA	4.9	4.90	NC
COU	Risk of Continued Opioid Use >= 30 Days (Total)	1.89	--	0	1.16	4.9	1.99	NC
CRE	Cardiac Rehabilitation - Achievement (18-64 Yrs)	2.42	--	NQ	0	0	0.81	◆
CRE	Cardiac Rehabilitation - Achievement (65 Yrs)	NA	--	NQ	NA	3.03	3.03	◆◆
CRE	Cardiac Rehabilitation - Achievement (Total)	2.34	--	NQ	0	1.22	1.19	◆
CRE	Cardiac Rehabilitation - Engagement 1 (18-64 Yrs)	0.61	--	NQ	0	0	0.20	◆
CRE	Cardiac Rehabilitation - Engagement 1 (65+ Yrs)	NA	--	NQ	NA	0	0.00	◆
CRE	Cardiac Rehabilitation - Engagement 1 (Total)	0.58	--	NQ	0	0	0.19	◆
CRE	Cardiac Rehabilitation - Engagement 2 (18-64 Yrs)	3.03	--	NQ	0	0	1.01	◆
CRE	Cardiac Rehabilitation - Engagement 2 (65 Yrs)	NA	--	NQ	NA	3.03	3.03	◆
CRE	Cardiac Rehabilitation - Engagement 2 (Total)	2.92	--	NQ	0	1.22	1.38	◆
CRE	Cardiac Rehabilitation - Initiation (18-64 Yrs)	0	--	NQ	0	0	0.00	◆
CRE	Cardiac Rehabilitation - Initiation (65+ Yrs)	NA	--	NQ	NA	0	0.00	◆
CRE	Cardiac Rehabilitation - Initiation (Total)	0	--	NQ	0	0	0.00	◆
CWP	Appropriate Testing for Children with Pharyngitis (18-64 Yrs)	76.46	--	76.47	74.96	63.89	72.95	◆◆
CWP	Appropriate Testing for Children with Pharyngitis (3-17 Yrs)	80.26	--	77.89	72.73	NA	76.96	◆
CWP	Appropriate Testing for Children with Pharyngitis (65+ Yrs)	NA	--	NA	NA	66.67	66.67	◆◆◆◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
CWP	Appropriate Testing for Children with Pharyngitis (Total)	78.25	--	77.52	73.85	65.59	73.80	◆
EED	Eye Exam for Patients With Diabetes	46.96	--	47.22	30.17	80.31	51.17	◆
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (13-17 Yrs)	NB	--	NA	NA	NA	ND	NC
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (18+ Yrs)	NB	--	NA	13.17	25.66	19.42	◆
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (Total)	NB	--	NA	13.18	25.66	19.42	◆
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (18+ Yrs)	NB	--	NA	7.32	11.18	9.25	◆
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (Total)	NB	--	NA	7.4	11.18	9.29	◆
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (13-17 Yrs)	NB	--	NA	NA	NA	NA	NC
FUH	Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (Total)	37.5	--	35	10.39	13.02	23.98	◆
FUH	Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (Total)	19.79	--	20	4.08	9.47	13.34	◆
FUH	Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (18-64 Yrs)	36.18	--	24.39	9.78	12.61	20.74	◆
FUH	Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	--	NA	NA	14	14.00	◆
FUH	Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (6-17 Yrs)	47.83	--	46.15	20	NA	37.99	◆
FUH	Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (18-64 Yrs)	18.15	--	9.76	3.59	8.4	9.98	◆
FUH	Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	--	NA	NA	12	12.00	◆
FUH	Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (6-17 Yrs)	32.17	--	30.77	11.43	NA	24.79	◆
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (Total)	NB	--	NA	29.19	31.82	30.51	◆
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (13-17 Yrs)	NB	--	NA	NA	NA	ND	NC

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (18-64 Yrs)	NB	--	NA	29.75	20	24.88	◆
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (65+ Yrs)	NB	--	NA	NA	47.37	47.37	◆ ◆
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (Total)	NB	--	NA	16.15	15.91	16.03	◆
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (13-17 Yrs)	NB	--	NA	NA	NA	ND	NC
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (18-64 Yrs)	NB	--	NA	16.46	8	12.23	◆
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (65+ Yrs)	NB	--	NA	NA	26.32	26.32	◆
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (Total)	43.28	--	59.65	15.95	14.29	33.29	◆
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (Total)	26.37	--	47.37	9.73	11.11	23.65	◆
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (18-64 Yrs)	38.51	--	NA	9.69	11.11	19.77	◆
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	--	NA	NA	NA	ND	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (6-17 Yrs)	56.6	--	68.89	63.33	NA	62.94	◆
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (18-64 Yrs)	20.61	--	NA	4.85	8.33	11.26	◆
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	--	NA	NA	NA	ND	NC
FUM	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (6-17 Yrs)	42.45	--	55.56	46.67	NA	48.23	◆
HBD	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)	51.82	--	36.11	52.31	71.05	52.82	◆
HBD	Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control	39.42	--	61.11	40.15	21.41	40.52	◆
HDO	Use of Opioids at High Dosage (HDO)	1.38	--	NA	0.65	2.47	1.50	◆ ◆ ◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
IET	Initiation and Engagement of Substance Use Disorder Treatment Initiation of SUD Treatment - Alcohol Use Disorder (Total)	NB	--	NA	34.48	38.89	36.69	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Initiation of SUD Treatment - Opioid Use Disorder (Total)	NB	--	NA	57.59	37.33	47.46	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Initiation of SUD Treatment - Other Drug Use Disorder (Total)	NB	--	NA	37.69	47.92	42.81	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Initiation of SUD Treatment - Total (13-17)	NB	--	NA	NA	NA	ND	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Initiation of SUD Treatment - Total (18-64)	NB	--	NA	38.23	41.90	40.07	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Initiation of SUD Treatment - Total (65+)	NB	--	NA	NA	42.13	42.13	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Initiation of SUD Treatment - Total (Total)	NB	--	16.67	38.59	42.04	32.43	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Engagement of SUD Treatment - Alcohol Use Disorder (Total)	NB	--	NA	3.69	4.81	4.25	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Engagement of SUD Treatment - Opioid Use Disorder (Total)	NB	--	NA	12.05	8.67	10.36	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Engagement of SUD Treatment - Other Drug Use Disorder (Total)	NB	--	NA	1.65	4.53	3.09	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Engagement of SUD Treatment - Total (13-17)	NB	--	NA	NA	NA	ND	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Engagement of SUD Treatment - Total (18-64)	NB	--	NA	3.56	4.74	4.15	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Engagement of SUD Treatment - Total (65+)	NB	--	NA	NA	6.02	6.02	◆
IET	Initiation and Engagement of Substance Use Disorder Treatment Engagement of SUD Treatment - Total (Total)	NB	--	0.00	3.58	5.55	3.04	◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
IMA	Immunizations for Adolescents - Combination 1	76.16	--	85.51	67.64	NA	76.44	◆
IMA	Immunizations for Adolescents - Combination 2	47.2	--	53.27	33.09	NA	44.52	◆ ◆ ◆
IMA	Immunizations for Adolescents - HPV	50.36	--	54.21	35.04	NA	46.54	◆ ◆ ◆
IMA	Immunizations for Adolescents - Meningococcal	76.89	--	86.92	70.8	NA	78.20	◆
IMA	Immunizations for Adolescents - Tdap/Td	83.7	--	87.85	71.05	NA	80.87	◆
KED	Kidney Health Evaluation for Patients With Diabetes (18-64 Yrs)	43.44	--	47.22	39.99	47.93	44.65	◆ ◆ ◆
KED	Kidney Health Evaluation for Patients With Diabetes (65-74 Yrs)	53.57	--	NA	43.14	52.65	49.79	◆ ◆
KED	Kidney Health Evaluation for Patients With Diabetes (75-85 Yrs)	40.98	--	NA	45.45	51.6	46.01	◆ ◆
KED	Kidney Health Evaluation for Patients With Diabetes (Total)	43.65	--	47.22	40.17	51.19	45.56	◆ ◆ ◆
LBP	Use of Imaging Studies for Low Back Pain	80.22	--	NA	77.43	72.09	76.58	◆ ◆ ◆
LSC	Lead Screening in Children	76.16	--	76	66.94	NA	73.03	◆ ◆ ◆
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	0.3	--	0.27	0.05	NA	0.21	◆ ◆
PBH	Persistence of Beta-Blocker Treatment after a Heart Attack	40.48	--	NA	NA	NA	40.48	◆
PCE	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	86.67	--	NQ	86.84	88.17	87.23	◆ ◆
PCE	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	70.74	--	NQ	67.11	63.24	67.03	◆
PCR	Plan All-Cause Readmissions (18-64)	0.8321	--	NA	0.9498	NA	0.89	◆ ◆ ◆
POD	Pharmacotherapy for Opioid Use Disorder (16-64 Yrs)	16.67	--	NA	16.43	43.33	25.48	◆ ◆
POD	Pharmacotherapy for Opioid Use Disorder (65+ Yrs)	NA	--	NA	NA	46.74	46.74	◆ ◆ ◆
POD	Pharmacotherapy for Opioid Use Disorder (Total)	16.67	--	NA	16.08	45.9	26.22	◆ ◆
PPC	Prenatal and Postpartum Care - Postpartum Care	76.76	--	53.33	68.62	NA	66.24	◆
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	82.7	--	70	75.8	NA	76.17	◆
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	46.37	--	NA	45.08	63.97	51.81	◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	--	NA	NA	NA	ND	NC
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	58.1	--	NA	55.88	77.27	63.75	◆
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (21-75 Yrs Male)	76.19	--	NA	78.88	87.25	80.77	◆ ◆
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (40-75 Yrs Female)	77.53	--	NA	80	84.25	80.59	◆ ◆
SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	76.86	--	NA	79.27	85.53	80.55	◆ ◆
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (21-75 Yrs Male)	68.75	--	NA	65.35	84.27	72.79	◆ ◆
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (40-75 Yrs Female)	60.8	--	NA	70.59	83.91	71.77	◆ ◆
SPC	Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	64.77	--	NA	67.18	84.07	72.01	◆ ◆
SPD	Statin Therapy for Patients With Diabetes - Received Statin Therapy	64.53	--	NA	64	79.8	69.44	◆ ◆ ◆
SPD	Statin Therapy for Patients With Diabetes - Statin Adherence 80%	57.96	--	NA	66.2	82.65	68.94	◆ ◆
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	20.21	--	NQ	12.59	20.12	17.64	◆
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	78.17	--	NA	75.63	86.9	80.23	NC
UOP	Use of Opioids From Multiple Providers - Multiple Pharmacies	4.85	--	NA	4.09	3.95	4.30	NC
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers	32.95	--	NA	34.78	23.81	30.51	NC
UOP	Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	3.35	--	NA	3.07	2.34	2.92	NC
URI	Appropriate Treatment for Upper Respiratory Infection (Total)	94.65	--	96.77	95.12	79.34	91.47	◆ ◆
URI	Appropriate Treatment for Upper Respiratory Infection (18-64 Yrs)	87.41	--	92.86	89.35	77.53	86.79	◆ ◆ ◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
URI	Appropriate Treatment for Upper Respiratory Infection (3 months-17 Yrs)	96.93	--	97.27	97.21	NA	97.14	◆◆◆◆
URI	Appropriate Treatment for Upper Respiratory Infection (65+ Yrs)	NA	--	NA	NA	80.09	80.09	◆◆
W30	Well-Child Visits in the First 30 Months of Life (15-30 Months)	40.43	--	21.95	26.05	NA	29.48	NC
W30	Well-Child Visits in the First 30 Months of Life (0-15 Months)	61.66	--	59.02	49.86	NA	56.85	◆
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (12-17 Yrs)	77.78	--	70.33	58.12	NA	68.74	NC
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (3-11 Yrs)	76.15	--	77.23	64.68	NA	72.69	NC
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	76.82	--	73.72	62.39	NA	70.98	NC
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 Yrs)	80.39	--	75.6	64.96	NA	73.65	NC
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 Yrs)	74.77	--	80.69	70.18	NA	75.21	NC
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	77.09	--	78.1	68.36	NA	74.52	NC
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 Yrs)	77.78	--	74.64	58.12	NA	70.18	NC
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 Yrs)	70.64	--	77.72	68.35	NA	72.24	NC
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	73.58	--	76.16	64.78	NA	71.51	NC
WCV	Child and Adolescent Well-Care Visits (12-17 Yrs)	61.17	--	63.03	45.69	NA	56.63	◆◆
WCV	Child and Adolescent Well-Care Visits (18-21 Yrs)	36.22	--	45.22	23.22	NA	34.89	◆◆◆◆

Measure		ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
WCV	Child and Adolescent Well-Care Visits (3-11 Yrs)	60.9	--	68.21	49.77	NA	59.63	◆ ◆
WCV	Child and Adolescent Well-Care Visits (Total)	57.2	--	61.38	44.63	NA	54.40	◆ ◆

HEDIS® – Health Care Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Benchmark source: NCQA Quality Compass Medicaid Health Maintenance Organization (HMO) for measurement year (MY 2023)

◆◆◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass 90th Percentile

◆◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile

◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile

◆ MCP rate is below the NCQA Quality Compass National Average

NA - Small Denominator: The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC - No Comparison: No Comparison made due to no rate and/or no benchmark available.

NQ - Not Required: The organization was not required to report the measure

NR - Not Reported: The organization chose not to report the measure.

-- AGP did not report HEDIS measures due to its contract start date of April 1, 2023.

Appendix 2 – CAHPS® Survey Results

CAHPS Health Plan Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey collects information on enrollees' experiences with health plans and their services. The table below includes 2024, measurement year (MY) 2023, CAHPS measure survey results for each District of Columbia managed care plan (MCP) and a comparison to the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO benchmarks. The MCP average is compared to benchmarks using a diamond rating system as defined below.

- ◆◆◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass 90th Percentile
- ◆◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile
- ◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile
- ◆ MCP rate is below the NCQA Quality Compass National Average

Table 1. Appendix 2 – CAHPS Health Plan Survey Measures, Medicaid Adult and Child

Member Experience - Medicaid Population	ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
ADULT MEDICAID SURVEY							
Getting Care							
Getting Needed Care Composite (% Always or Usually)	75.7	NA	NA	NA	82.72	79.21	◆
Ease of Getting Needed Care (% Always or Usually)	77.04	NA	NA	NA	85.82	81.43	◆
Ease of Seeing a Specialist (% Always or Usually)	74.36	NA	NA	NA	79.61	76.99	◆
Getting Care Quickly Composite (% Always or Usually)	74.47	NA	NA	NA	81.97	78.22	◆
Ease of Getting Urgent Care (% Always or Usually)	76.67	NA	NA	NA	83.18	79.93	◆
Ease of Getting a Check-up or Routine Care (% Always or Usually)	72.28	NA	NA	NA	80.77	76.53	◆
Satisfaction with Physicians							
Rating of Personal Doctor (% 9 or 10)	71.06	NA	NA	NA	80.44	75.75	◆◆◆◆
Rating of Specialist Seen Most Often (% 9 or 10)	61.07	NA	NA	NA	72.46	66.77	◆
Rating of All Health Care (% 9 or 10)	59.49	NA	NA	NA	63.12	61.31	◆◆◆
Coordination of Care (% Always or Usually)	84.43	NA	NA	NA	86.54	85.49	◆
Overall Ratings							
Rating of Health Plan (% 8, 9 or 10)	78.15	NA	81.65	NA	86.48	82.09	◆◆◆

Member Experience - Medicaid Population	ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
Rating of All Health Care (% 8, 9 or 10)	76.92	NA	NA	NA	78.47	77.70	♦ ♦
Rating of Personal Doctor (% 8, 9 or 10)	85.96	NA	NA	NA	87.27	86.62	♦ ♦ ♦
Rating of Specialist Seen Most Often (% 8, 9 or 10)	73.83	NA	NA	NA	83.53	78.68	♦
Additional Measures							
How Well Doctors Communicate Composite (% Always or Usually)	90.65	NA	NA	NA	94.94	92.80	♦
Doctor Explained Things (% Always or Usually)	89.39	NA	NA	NA	94.52	91.96	♦
Doctor Listened Carefully (% Always or Usually)	92.39	NA	NA	NA	95.45	93.92	♦ ♦
Doctor Showed Respect (% Always or Usually)	94.44	NA	NA	NA	96.93	95.69	♦ ♦
Doctor Spent Enough Time (% Always or Usually)	86.36	NA	NA	NA	92.86	89.61	♦
Customer Service Composite (% Always or Usually)	87.5	NA	NA	NA	91.91	89.71	♦ ♦
Customer Service Provided Information/Help (% Always or Usually)	84.03	NA	NA	NA	87.62	85.83	♦ ♦
Customer Service Was Courteous/Respectful (% Always or Usually)	90.97	NA	NA	NA	96.2	93.59	♦
Forms Easy to Fill Out (No + Usually + Always)	95.21	NA	93.4	NA	93.94	94.18	♦
Additional Adult Medicaid Effectiveness of Care Measures							
Flu Vaccinations for Adults (% Yes)		NA				ND	NC
Advising Smokers and Tobacco Users to Quit (% Sometimes, Usually, or Always)	77.05	NA	NA	NA	90.35	83.70	♦ ♦ ♦ ♦
Discussing Cessation Medications (% Sometimes, Usually, or Always)	57.14	NA	NA	NA	71.6	64.37	♦ ♦ ♦ ♦
Discussing Cessation Strategies (% Sometimes, Usually, or Always)	51.69	NA	NA	NA	63.81	57.75	♦ ♦ ♦ ♦
CHILD MEDICAID SURVEY							
Getting Care							
Getting Needed Care Composite (% Always or Usually)	NA	NA	78.08	NA	ND	78.08	♦
Ease of Getting Needed Care (% Always or Usually)	79.34	NA	79.58	NA	ND	79.46	♦
Ease of Seeing a Specialist (% Always or Usually)	NA	NA	76.58	NA	ND	76.58	♦
Getting Care Quickly Composite (% Always or Usually)	NA	NA	84.09	NA	ND	84.09	♦
Ease of Getting Urgent Care (% Always or Usually)	NA	NA	NA	NA	ND	ND	NC

Member Experience - Medicaid Population	ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
Ease of Getting a Check-up or Routine Care (% Always or Usually)	76.38	NA	78.71	NA	ND	77.55	◆
Satisfaction with Physicians							
Rating of Personal Doctor (% 9 or 10)	79.61	NA	71.3	NA	ND	75.46	◆
Rating of Specialist Seen Most Often (% 9 or 10)	NA	NA	66.34	NA	ND	66.34	◆
Rating of All Health Care (% 9 or 10)	67.21	NA	62.3	NA	ND	64.76	◆
Coordination of Care (% Always or Usually)	NA	NA	NA	NA	ND	ND	NC
Overall Ratings							
Rating of All Health Care (% 8, 9 or 10)	86.07	NA	83.25	NA	ND	84.66	◆
Rating of Personal Doctor (% 8, 9 or 10)	91.45	NA	84.35	NA	ND	87.90	◆
Rating of Specialist Seen Most Often (% 8, 9 or 10)	NA	NA	87.13	NA	ND	87.13	◆
Rating of Health Plan (% 8, 9 or 10)	88.89	NA	77.86	NA	ND	83.38	◆
Rating of Health Plan (9+10)	75.66	NA	61.25	NA	ND	68.46	◆
Additional Measures							
How Well Doctors Communicate Composite (% Always or Usually)	91.51	NA	90.18	NA	ND	90.85	◆
Doctor Explained Things (% Always or Usually)	90.83	NA	92.86	NA	ND	91.85	◆
Doctor Listened Carefully (% Always or Usually)	93.58	NA	92.78	NA	ND	93.18	◆
Doctor Showed Respect (% Always or Usually)	94.5	NA	93.89	NA	ND	94.20	◆
Doctor Spent Enough Time (% Always or Usually)	87.16	NA	81.22	NA	ND	84.19	◆
Customer Service Composite (% Always or Usually)	NA	NA	87.59	NA	ND	87.59	◆
Customer Service Provided Information/Help (% Always or Usually)	NA	NA	79.56	NA	ND	79.56	◆
Customer Service Was Courteous/Respectful (% Always or Usually)	NA	NA	95.62	NA	ND	95.62	◆ ◆
Forms Easy to Fill Out (No + Usually + Always)	96.28	NA	96.31	NA	ND	96.30	◆ ◆
Additional Child Medicaid Children with Chronic Conditions (CCC) Population Measure Survey							
Getting Needed Information (% Always or Usually)	ND	NA	78.26	NA	ND	78.26	◆
Access to Prescription Medicines (% Always or Usually)	ND	NA	66.48	NA	ND	66.48	◆ ◆
Coordination of Care for Children With Chronic Conditions (% Yes)	ND	NA	NA	NA	ND	ND	NC
Personal Doctor Who Knows Child (% Yes)	ND	NA	90.49	NA	ND	90.49	◆

Member Experience - Medicaid Population	ACDC %	AGP %	HSCSN %	MFC %	UHC %	MCP AVG %	Comparison to Benchmarks
Access to Specialized Services (% Always or Usually)	ND	NA	NA	NA	ND	ND	NC
Rating of Health Plan (9+10)	ND	NA	58.97	NA	ND	58.97	◆

CAHPS® – is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

◆◆◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass 90th Percentile

◆◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile

◆◆ MCP rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile

◆ MCP rate is below the NCQA Quality Compass National Average

NA - Small Denominator: The organization followed the specifications, but the denominator was too small (<100) to report a valid rate

NC - No Comparison: No Comparison made due to no rate or/and no benchmark available

ND - No Data: No rate reported due to new measure, measure retired, or survey not conducted

Appendix 3 – Maternal Health and Birth Outcomes Focus Study Report Summary

Objective

The District of Columbia (DC or the District) Department of Health Care Finance (DHCF) seeks to improve the health and well-being of the District's residents. DHCF's aim to achieve *Healthy People* and a *Healthy Community*, as described in its Medicaid Managed Care Quality Strategy, includes improving the health of pregnant women and babies.¹ According to the March of Dimes:²

- In 2022, 1 in 10 babies (10.2% of live births) was born preterm in the District of Columbia.
- In 2022, 1 in 10 babies (9.8% of live births) had low birthweight in the District of Columbia.
- In the District of Columbia in 2022, 63.0% of infants were born to women receiving adequate/adequate plus prenatal care.
- The rate of preterm birth in the District of Columbia is highest for Black infants (13.3%), followed by Hispanics (9.3%), Asian/Pacific Islanders (7.6%) and Whites (6.6%).
- Preterm birth was rated as C- in the District of Columbia 2023 Report Card.

To better understand maternal health and birth outcomes within the District's Medicaid managed care population, DHCF initiated a multiyear focus study. DHCF tasked Qlarant with conducting a Maternal Health and Birth Outcomes Focus Study by answering the following study questions:

1. To what extent are Medicaid managed care enrollees, who have given birth, receiving early and adequate prenatal care?
2. Do birth outcomes appear to correlate with the level of prenatal care received?
3. Do disparities exist in the adequacy of prenatal care and birth outcomes based on race/ethnicity and/or residence by ward?

DHCF seeks to identify gaps in care and prioritize opportunities to target in order to achieve *Healthy People* and a *Healthy Community* within the District. To assist DHCF in this endeavor, Qlarant analyzed the maternal health and birth outcomes of mothers who were enrolled in one of the following Medicaid managed care programs at the time they gave birth:

- District of Columbia Healthy Families Program (DCHFP), which includes three managed care plans (MCPs):
 - AmeriHealth Caritas District of Columbia (ACDC)
 - Amerigroup District of Columbia (AGP), which replaced CareFirst Community Health Plan District of Columbia (CFDC), effective April 1, 2023³
 - MedStar Family Choice District of Columbia (MFC)
- Child and Adolescent Supplemental Security Income Program (CASSIP), which includes one MCP:
 - Health Services for Children with Special Needs (HSCSN)

¹ [DHCF Medicaid Managed Care Quality Strategy](#)

² [March of Dimes 2022 PeriStats - The March of Dimes obtains peristats from the National Center for Health Statistics, which collaborates with public and private health partners to obtain data.](#)

³ On April 1, 2023, AGP replaced CareFirst Community Health Plan District of Columbia (CFDC). DHCF's contract with CFDC ended on March 31, 2023.

Methodology

Qlarant's 2024 Maternal Health and Birth Outcomes Focus Study analyzed the District's Medicaid managed care enrollees who were continuously enrolled for at least 120 days and had a live birth during fiscal year (FY) 2023, which spanned from October 1, 2022 through September 30, 2023. The study, conducted in 2024, serves as a baseline assessment.

Description of Data Obtained. Qlarant obtained the following data from DHCF to complete the focus study:

- An encounter file that contained claims for services provided January 2022 through September 2023, which permitted a review of prenatal care received prior to the deliveries that occurred early in the measurement period.
- A membership file that encompassed enrollee demographics, which was used to identify enrollee date of birth and address.
- An enrollment file that included affiliated MCP and enrollment dates, which helped identify program(s)/MCP(s) the enrollee was enrolled with and the corresponding enrollment date(s).

Technical Methods of Data Collection and Analysis. Qlarant conducts focus study activities in a manner consistent with the *Centers for Medicare and Medicaid Services (CMS) EQR Protocol 9, Conducting Focus Studies of Health Care Quality*.⁴ To help answer the focus study's questions, Qlarant calculated the following performance measures:

- **Births with Early and Adequate Prenatal Care.** The percentage of births with an Adequacy of Prenatal Care Utilization (APNCU) Index (Kotelchuck Index) score greater than or equal to 80% (i.e., women who received at least 80% of expected prenatal visits).
- **Births with Inadequate Prenatal Care.** The percentage of births with an APNCU Index score of less than 50% (i.e., women who received less than 50% of expected prenatal care visits).
- **Births with No Prenatal Care.** The percentage of births with no prenatal care.
- **Preterm Births (<37 Weeks Gestation).** The percentage of births before 37 completed weeks of gestation.
- **Newborns with Low Birth Weight.** The percentage of newborns identified with low birth weight and preterm delivery of less than 37 week.

Qlarant calculated each study measure and analyzed data based on MCP enrollment, age of the mother, and residential ward.

Results

A summary of the study's results, with respect to each study question, is described below.

⁴ [CMS EQR Protocols](#)

1. To what extent are Medicaid managed care enrollees, who have given birth, receiving early and adequate prenatal care?

Table 1 identifies the rate of early and adequate prenatal care by MCP. Table 2 specifies the statistical significance testing result for the measure.

Table 1. Early and Adequate Prenatal Care by MCP

MCP	Frequency	N	Percent
ACDC	624	1,206	51.74%
AGP	100	248	40.32%
CFDC	118	266	44.36%
HSCSN	16	32	50.00%
MFC	284	589	48.22%
No MCP Specified*	33	88	37.50%
Total	1,175	2,429	48.37%

Table 2. ANOVA Results for Early and Adequate Prenatal Care by MCP

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	5	4.4539561	0.8907912	3.58	0.0031 ^{SS}

SS - Statistically significant result

On average, 48.37% of DC Medicaid managed care enrollees received early and adequate prenatal care for FY 2023 births. This rate compares unfavorably to the District of Columbia Adequate/Adequate Plus Prenatal Care rate of 63.0%, and the national average of 74.9%, as reported by the March of Dimes.⁵ Caution is advised when comparing performance.⁶

ACDC enrollees achieved the highest rate of early and adequate prenatal care (51.74%). Enrollees with no specified MCP had the lowest rate of early and adequate prenatal care (37.50%). The MCP variances in rates of early and adequate prenatal care are statistically significant ($F=3.58$, $p=0.003$); the differences are substantially greater than what could be expected due to random variation alone. On average, less than half of enrollees received early and adequate prenatal care (48.37%). Only ACDC and HSCSN enrollees achieved 50% or greater of expected care.

Table 3 identifies the rate of early and adequate prenatal care by enrollee age. Table 4 specifies the statistical significance testing result for the measure.

Table 3. Early and Adequate Prenatal Care by Age

Age	Frequency	N	Percent
10-19 Years	71	155	45.81%
20-29 Years	550	1,217	45.19%
30-39 Years	503	970	51.86%
40-49 Years	51	87	58.62%
Total	1,175	2,429	48.37%

⁵ [March of Dimes 2022 PeriStats](#)

⁶ There are variations in populations, calculations, timeframes, and data sources. Medicaid managed care data sources include encounter/claims data. March of Dimes data sources include vital statistics.

Table 4. ANOVA Results for Early and Adequate Prenatal Care by Age

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	3	3.4228483	1.1409494	4.59	0.0033 ^{SS}

SS - Statistically significant result

Enrollees aged 40-49 achieved the highest rate of early and adequate prenatal care (58.62%). Enrollees aged 20-29 had the lowest rate of early and adequate prenatal care (45.19%). The enrollee age variances in rates of early and adequate prenatal care are statistically significant ($F=4.59$, $p=0.003$); the differences are substantially greater than what could be expected due to random variation alone. Only enrollees aged 30-39 and 40-49 achieved 50% or greater of expected care.

Table 5 identifies the rate of early and adequate prenatal care by enrollee ward. Table 6 specifies the statistical significance testing result for the measure.

Table 5. Early and Adequate Prenatal Care by Ward

Ward	Frequency	N	Percent
1	78	151	51.66%
2	25	52	48.08%
3	21	48	43.75%
4	127	229	55.46%
5	146	295	49.49%
6	73	161	45.34%
7	267	550	48.55%
8	302	675	44.74%
No Ward Specified [^]	136	268	50.75%
Total	1,175	2,429	48.37%

[^] The DHCF membership file did not specify a ward for the enrollee.

Table 6. ANOVA Results for Early and Adequate Prenatal Care by Ward

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	8	2.6434254	0.3304282	1.32	0.2265

Enrollees in Ward 4 achieved the highest rate of early and adequate prenatal care (55.46%). Enrollees in Ward 3 had the lowest rate of early and adequate prenatal care (43.75%). The ward variances in rates of early and adequate prenatal care are not statistically significant ($F=1.32$, $p = 0.227$); the observed differences in ward are likely attributable to chance variation. Only enrollees in wards 1 and 4, and enrollees with no specified ward, achieved 50% or greater of expected care.

2. Do birth outcomes appear to correlate with the level of prenatal care received?

To understand whether or not early and adequate prenatal care correlates with preterm birth or low birth weight, Qlarant used Fisher's Exact tests to determine significant associations for all of DC and for each MCP, age range, and DC Ward. Tables 7-12 display results.

Table 7. Correlation of Early and Adequate Prenatal Care and Preterm Births by MCP

MCP	Fisher Exact Test	Two-Sided Pr <=P
ACDC	532	0.0979
AGP	130	0.6850
CFDC	129	0.0645
HSCSN	12	0.6539
MFC	272	0.0054 ^C
No MCP Specified*	50	0.4036
Total	1,125	0.0002 ^C

* The DHCF enrollment file did not specify an MCP for the enrollee.

C - Correlation exists

Qlarant concludes a correlation exists between early and adequate prenatal care and preterm births for all DC. An evaluation of each MCP concludes a correlation also exists between early and adequate prenatal care and preterm births for MFC.

Table 8. Correlation of Early and Adequate Prenatal Care and Preterm Births by Age

Age	Fisher Exact Test	Two-Sided Pr <=P
10-19 Years	74	0.2611
20-29 Years	594	0.0006 ^C
30-39 Years	425	0.3446
40-49 Years	32	0.1551
Total	1,125	0.0002 ^C

C - Correlation exists

An evaluation of each age range concludes a correlation exists between early and adequate prenatal care and preterm births for enrollees 20-29 years of age.

Table 9. Correlation of Early and Adequate Prenatal Care and Preterm Births by Ward

Ward	Fisher Exact Test	Two-Sided Pr <=P
1	60	0.0850
2	24	1.0000
3	25	1.0000
4	97	1.0000
5	142	1.0000
6	84	1.0000
7	247	0.0693
8	328	0.0006 ^C
No Ward Specified [^]	118	0.5327
Total	1,125	0.0002 ^C

[^] The DHCF membership file did not specify a ward for the enrollee.

C - Correlation exists

An evaluation of each ward concludes a correlation exists between early and adequate prenatal care and preterm births for Ward 8 enrollees.

Table 10. Correlation of Early and Adequate Prenatal Care and Low Birth Weight by MCP

MCP	Fisher Exact Test	Two-Sided Pr <=P
ACDC	529	0.0500 ^C
AGP	130	0.6850
CFDC	128	0.1656
HSCSN	12	0.6539
MFC	270	0.0024 ^C
No MCP Specified*	49	0.2484
Total	1,118	<.0001 ^C

* The DHCF enrollment file did not specify an MCP for the enrollee.

C - Correlation exists

Qlarant concludes a correlation exists between early and adequate prenatal care and low birth weight for all DC. An evaluation of each MCP concludes a correlation also exists between early and adequate prenatal care and low birth weight for ACDC and MFC.

Table 11. Correlation of Early and Adequate Prenatal Care and Low Birth Weight by Age

Age	Fisher Exact Test	Two-Sided Pr <=P
10-19 Years	72	0.1112
20-29 Years	592	0.0005 ^C
30-39 Years	422	0.2064
40-49 Years	32	0.1551
Total	1,118	<.0001 ^C

C - Correlation exists

An evaluation of each age range concludes a correlation exists between early and adequate prenatal care and low birth weight for enrollees 20-29 years of age.

Table 12. Correlation of Early and Adequate Prenatal Care and Low Birth Weight by Ward

Ward	Fisher Exact Test	Two-Sided Pr <=P
1	59	0.0534
2	24	1.0000
3	25	1.0000
4	97	1.0000
5	142	1.0000
6	84	1.0000
7	245	0.0389 ^C
8	324	0.0003 ^C
No Ward Specified [^]	118	0.5327
Total	1,118	<.0001 ^C

[^] The DHCF membership file did not specify a ward for the enrollee.

C - Correlation exists

An evaluation of each ward concludes a correlation exists between early and adequate prenatal care and low birth weight for Wards 7 and 8 enrollees.

3. Do disparities exist in the adequacy of prenatal care and birth outcomes based on race/ethnicity and/or residence by ward?

According to the *United States Department of Health and Human Services - Health Resources & Services Administration, HRSA Maternal & Child Health Study*, Wards 7 and 8 are predominantly comprised of black residents, 92% and 90%, respectively. Wards 7 and 8 have a higher rate of poverty compared to other wards. Rates of poverty include 27% and 36%, respectively. Additionally, most heads of household are single females, 72% and 70%, respectively.⁷

More than half of Medicaid managed care enrollee birth mothers reside in Wards 7 and 8. The early and adequate prenatal care rates in Wards 7 and 8 are 48.55% and 44.74%, respectively. The early and adequate prenatal care District average is 48.37%.

Wards 7 and 8 preterm birth and low birth weight rates compared unfavorably to the averages:

- Preterm births (lower rate is better) - Ward 7: 10.24%, Ward 8: 9.02%, and Average 8.40%.
- Low birth weight (lower rate is better) - Ward 7: 10.58%, Ward 8: 9.85%, and Average: 8.79%.

The March of Dimes reporting confirmed preterm birth rates were highest in Wards 7 and 8, compared to other wards within the District.⁸

Qlarant determined the variances in preterm birth and low birth weight by ward are statistically significant. It appears disparities exist in Wards 7 and 8 in relation to birth outcomes, compared to other wards.

An analysis of race and ethnicity was not completed as a result of limitations in the data received from DHCF. The membership file did not contain race and ethnicity data. While race and ethnicity cannot be reported specific to this study, the March of Dimes offers the following statistics:

- The rate of preterm birth in the District of Columbia is highest for Black newborns (13.3%), followed by Hispanics (9.3%), Asian/Pacific Islanders (7.6%) and Whites (6.6%).⁹
- Black women in the District of Columbia travel 1.9 times farther to reach their nearest birthing hospital compared to all other races. Despite adjusting for distance traveled to care and maternal age, Black women were 2.1 times more likely to have a preterm birth when compared to White women in the District of Columbia.¹⁰

Conclusion

Strengths

On average, 8.40% of DC Medicaid managed care births were considered preterm during FY 2023. This rate compares favorably to the District of Columbia preterm birth rate of 10.2%, and the national rate of

⁷ [HRSA Maternal & Child Health Study - District of Columbia](#)

⁸ [Where You Live Matters: Maternity Care in the District of Columbia \(March of Dimes\)](#)

⁹ [March of Dimes PeriStats](#)

¹⁰ [Where You Live Matters: Maternity Care in the District of Columbia \(March of Dimes\)](#)

10.4%, as reported by the March of Dimes. However, some MCPs have opportunities for improvement. All MCPs should strive to achieve or exceed the Healthy People 2030 target of 9.4%.¹¹

On average, 8.79% of DC Medicaid managed care newborns were considered low birth weight during FY 2023. This rate compares favorably to the District of Columbia low birth rate of 9.8%. The national average of 8.6%, as reported by the March of Dimes.

MCPs, as evidenced by their annual PIP reports, have an understanding of their barriers to improvement in prenatal care. Understanding these barriers help inform effective improvement strategies.

Recommendations

MCPs should focus efforts on improving the rate of early and adequate prenatal care. MCP performance in this measure fell short in meeting local and national benchmarks—DC MCP enrollees: 48.37%, DC All: 63.0% (source: March of Dimes), National: 74.9% (source: March of Dimes). Fewer than 50% of AGP, CFDC, and MFC enrollees received early and adequate prenatal care. No MCP met the benchmarks.

DHCF should consider:

- Encouraging strong participation and engagement in the Maternal Health Advisory Group. This group seeks to get input from a variety of stakeholders, identify priorities, and implement project plans that aim to improve maternal health and birth outcomes.
- Continuing implementation and expansion of doula services and addressing barriers as they present. Doula services are provided throughout the perinatal and postpartum periods and aim to improve maternal health outcomes. Services include: (1) perinatal counseling and education, including infant care, to prevent adverse outcomes; (2) labor support and attendance at delivery, including the development of a birth plan; and (3) coordination with community-based services, to improve enrollee outcomes. Doulas can aid in bridging services that help close gaps in care.
- Promoting use of telehealth services. Telehealth is healthcare delivered using technology to replace or enhance in-person care and can save lives by providing high quality care for pregnant and postpartum people. Telehealth access is especially important to women who are underserved, vulnerable to poor health outcomes, and have limited access to high risk care.¹²
- Continuing participation in the Perinatal Mental Health Task Force. This task force brought together diverse stakeholders, including government representatives from behavioral health, Medicaid, public health, and the DC Council. Additionally, members representing various fields including medicine, mental health, nursing, midwifery, doula services, community-based organizations, health centers, and MCPs are actively participating. The task force is working to enhance access, continuity of care, accountability, and workforce.
- Requiring MCPs develop a collaborative intervention that specifically targets enrollees in Wards 7 and 8. These wards are the most vulnerable and have a significant opportunity for improvement. Examples of potential interventions include:
 - Increasing the number of community resources, including providing access to more mid-level providers such as midwives and nurse practitioners; increasing the number of and access to doulas.

¹¹ [Healthy People 2030 - Reduce Preterm Births](#)

¹² [Where You Live Matters: Maternity Care in the District of Columbia \(March of Dimes\)](#)

- Increasing opportunity for and access to social supports. This type of support may improve pregnancy outcomes indirectly by helping pregnant women obtain adequate prenatal care (by assisting enrollees in keeping their appointments). Social support may also improve pregnancy outcomes directly by interpreting and reinforcing provider instructions, by reducing stress through counseling and helping women become part of supportive social networks, and by educating them about nutrition, substance abuse, medications, and other vital topics.¹³
- Developing a special campaign to promote availability of transportation to and from prenatal care appointments. Lack of enrollee transportation is a significant barrier to obtaining prenatal care; MCPs report this barrier in their PIP reports year after year.
- Providing centering pregnancy (CP) programs. The CP program provides group prenatal care, which has been associated with improved outcomes for preterm birth and low birthweight, increased rates of breastfeeding, and higher rates of patient and clinician satisfaction. Retrospective studies of CP programs demonstrate improved maternal, neonatal, postpartum, and well-being outcomes, especially for participants from minority backgrounds.¹⁴

DHCF and the MCPs are encouraged to instruct providers to use consistent billing practices. Consistent, accurate billing practices provide opportunity for more comprehensive and meaningful data analysis.

DHCF may want to consider exploring why there is no MCP assignment for some enrollees in the enrollment file.

¹³ [National Institutes of Health - Social Supports](#)

¹⁴ [National Institutes of Health - Centering Pregnancy](#)

41. Federal regulations require an annual program independent review of the Medicaid Managed Care program. Please provide a copy of the review for FY 2025, or the most recent review conducted. Also include the following information:

- a. The agency's response to the key findings and conclusions; and**
- b. Action plans for addressing the review's key findings and conclusions.**

Response:

Federal regulations require an annual independent program review of the Medicaid Managed Care program to be performed by an External Quality Review Organization (EQRO). To comply with the requirement, the Department of Health Care Finance (DHCF) contracts with Qlarant, an external quality review organization (EQRO), to conduct annual, independent reviews of the District's MCPs, as required in the Code of Federal Regulations (42 CFR §438.350). Qlarant assesses MCP compliance with federal and DHCF-specific requirements by conducting several audit reviews including;

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review also referenced as Operational Systems Review (OSR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Network Adequacy Survey Focus Study
- Maternal Health and Birth Outcomes Focus Study

The most recent review is the 2024 Annual Technical Report (ATR) that can be found by clicking [here](#) OR provided as an attachment. The 2025 ATR will be available April 2026.

a. The agency's response to the key findings and conclusions;

Key findings and MCP performance for the four (4) participating Managed Care Plans (AmeriHealth, MedStar, Wellpoint formerly Amerigroup, and HSCSN) are below.

- **Performance Improvement Project Validation.** The MCPs conducted two PIPs each and reported performance measure results for MY2023 (MY: Measurement Year), as applicable. All MCPs were required to participate in a new Behavioral Health PIP and report baseline performance, as applicable. Amerigroup (AGP) was unable to report baseline performance due to the April 1, 2023, contract effective date. The MCPs' overall PIP validation scores ranged from 85.7%-100%. The DCHFP MCPs restarted their Maternal Health PIP. The MCPs reported baseline performance, as applicable, with AGP unable to report baseline performance due to the contract start period. Overall validation scores ranged from 94.6%-100%. HSCSN, reported second measurement results for the Childhood Obesity

Management and Prevention PIP. The MCP achieved mixed results in the PIP measures and received an overall validation score of 84.0%.

- **Performance Measure Validation.** Qlarant conducted two PMV audits during 2024. The first audit focused on validating the accuracy of select PIP and CMS Adult and Child Core Set measures. The second audit focused on validating the accuracy of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) measures. Information Systems Capabilities Assessments (ISCAs) determined that the MCPs had appropriate systems in place to process accurate claims and encounters, which were used to calculate performance measure rates. MCPs received overall PMV ratings of 100% for the PIP and Core measures and 100% for the EPSDT measures.
- **Operational Systems Review.** Qlarant conducted a comprehensive OSR in 2024. The MCPs provided evidence of having operational systems, policies, and staff in place to support core processes necessary to deliver services to enrollees. MCP scores ranged from 96-100% (rounded from 99.72%). All MCPs were required to develop and implement corrective action plans (CAPs) to address noncompliance with standards, most of which related to the Grievance and Appeal System Standard.
- **Network Adequacy Validation.** All MCPs demonstrated high confidence in how they calculate and report compliance with the District's provider network adequacy standards. All MCPs received a high confidence rating in each indicator they reported, except MFC, receiving a moderate confidence rating in one pharmacy indicator. All MCPs failed to report all required indicators to DHCF. Each MCP omitted between three and 17 indicators. MCPs must include these indicators in their future reports. Reporting all required indicators provides DHCF with a complete picture of MCPs' compliance levels.
- **Encounter Data Validation.** A medical record review resulted in an overall encounter data accuracy rate of 94.5%, a 4.7 percentage point improvement over the previous annual MCP average of 89.8%. Individual MCP performance ranged from 90.9%-97.6%. Insufficient documentation in the medical record was the most frequent contribution to noncompliance.
- **Network Adequacy Survey Focus Study.** All MCPs have robust provider networks and demonstrated compliance with geographic and provider-to-enrollee requirements, as applicable. During 2024, DCHFP and CASSIP MCP performance ranged from 77%-100% for timely access to routine and urgent care for both adults and children. Performance improved over the last year for adult access to routine and urgent appointments and pediatric access to routine and urgent appointments. Overall provider directory accuracy declined with the DCHFP and CASSIP MCP average dropping from 56% to 41% in MY 2024.

- **Maternal Health and Birth Outcomes Focus Study.** The first annual assessment was conducted in 2024. On average, 48% of Managed Care enrollees received early and adequate prenatal care. Birth mothers aged 40-49 years were most frequently the recipients of this care. Correlations between early and adequate prenatal care and birth outcomes were identified by MCP, birthing person's age, and District Ward. More than half of Medicaid managed care enrollee births are to residents in Wards 7 and 8, where early and adequate prenatal care rates were 49% and 45%, respectively. An analysis of race and ethnicity was not completed as a result of limitations in the data. The study will continue to identify trends and possible impacts of interventions.

Based on these findings, Qlarant's conclusions are as follows:

- In terms of quality and timely access to care, on average, MCPs 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.
- While PIP performance measure results were mixed, there were signs of improvement in timely access to PCP appointments. MCP HEDIS and CAHPS performance, on average, did not compare favorably to national average benchmarks.
- Overall, MCPs improved compliance with structural and operational standards in the OSR. Qlarant attributes this improvement to DHCF's enhanced quality improvement approach and closely monitoring MCP performance and compliance, and as needed, corrective actions.

b. Action plans for addressing the review's key findings and conclusions.

DHCF continues to monitor and track MCP performance to ensure all MCPs remain compliant, in addition to partnering with the MCPs to develop strategies and plans of action for opportunities for improvement.

42. DHCF shared in its FY 2024 performance oversight responses that they are in the initial phases of reviewing the Value Based Payment (VBP) arrangements established by the MCOs. Please share what DHCF has done in FY 2025 and FY 2026 to prepare the report on Medicaid MCO value-based purchasing, and an anticipated publication date for the report.

a. Please share what the annual adoption targets that each MCO VBP must meet are.

Response:

In FY2025, DHCF developed a Value-Based Purchasing (VBP) Framework for Medicaid managed care plans (MCPs). In support of public reporting and ongoing VBP oversight, the Framework defines the overall structure and performance expectations (including priority domains, standardized measure alignment, and monitoring requirements), streamlines DHCF's collection of MCP-submitted VBP data, and specifies the data sources DHCF will use for annual performance monitoring.

In December 2025, DHCF collected projected FY2026 data for the MCPs' VBP arrangements to support program oversight and public reporting in advance of implementation, which will begin for MCPs on January 1, 2026. The anticipated publication date for the CY2025 VBP report is September 2026. This allows for a customary claims' run-out period to collect a comprehensive data set of information.

- a.** DHCF has established target levels for the share of total medical expenditures that must be under VBP arrangements and has specified the applicable Health Care Payment Learning and Action Network (HCP-LAN) categories. The chart below summarizes the targets for CY2026 and CY2027.

Calendar Year	Required Percentage of Total Medical Expenditures Through VBP Arrangements (2C or Above)
2026	50%*

*For purposes of satisfying the requirement that 50% of total medical expenditures are in VBP arrangements in LAN categories 2C and above, MCPs must:

- Ensure at least one-half (25%) of qualifying total medical expenditures are through models in LAN categories 3–4
- Ensure at least one-quarter (12.5%) of qualifying total medical expenditures are associated with a VBP arrangement in the maternal, pediatric, or primary/preventive care domain
- Ensure each VBP arrangement includes at least one measure from the associated domain subcategory outlined on the preferred measures list (if the VBP arrangement is in the maternal, pediatric, or primary/preventive care domain)

2027	60%**

**For purposes of satisfying the requirement that 60% of total medical expenditures are in VBP arrangements in LAN categories 2C and above, MCPs must:

- Ensure at least one-half (30%) of qualifying total medical expenditures are through models in LAN categories 3–4
- Ensure at least one-quarter (15%) of qualifying total medical expenditures are associated with a VBP arrangement in the maternal, pediatric, or primary/preventive care domain
- Ensure each VBP arrangement includes at least one measure from the associated domain subcategory outlined on the preferred measures list (if the VBP arrangement is in the maternal, pediatric, or primary/preventive care domain)

43. Please provide FY 2025 and FY 2026 to date accreditation status for each MCO and any other entities that DHCF requires accreditation for, including what entity is performing the accreditation and their accreditation standards.

Response:

The District's Managed Care Plans are contractually obligated to be accredited by National Committee on Quality Assurance (NCQA), an independent 501(c)(3) non-profit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. Table 1 below lists each MCPs' accreditation type and achievement date. NCQA's accreditation spans 3 years.

Table 1: Managed Care Plan Accreditation

Managed Care Plan	Accreditation Type	Date Received
AmeriHealth Caritas DC	NCQA Health Equity	May 2024
	NCQA Case Management	August 2023
	NCQA Health Plan	October 2024
MedStar Family Choice	NCQA Health Plan	February 2023
	NCQA Case Management	February 2025
Wellpoint, formerly Amerigroup	NCQA Health Plan	June 2025
	NCQA Health Equity	November 2025
HSCSN	NCQA Health Plan	August 2024
	NCQA Case Management	July 2024

**Alliance Adult and Child Utilization
FY2025**

Provider type description	Total paid claims	Total unique beneficiaries with at least one claim
Adult Day Care	0	0
Adult Day Health 1915(i)	0	0
Adv Practice Registered Nurse	0	0
Ambulance, Air Transport	1	1
Ambulance, Private	10,185	311
Ambulance, Public	844	593
Ambulatory Surgical Centers	377	322
Audiologist	125	17
Behavioral Hlth Stabilization	0	0
Birthing Centers	1	1
Clinic, Adlt Alc/Subst Abuse	0	0
Clinic, Dental	0	0
Clinic, Family Planning	125	71
Clinic, Fed Qualified Health	75,095	17,931
Clinic, Mental Health	133	9
Clinic, Private	800	202
Clinic, Youth Alc/Subst Abuse	8	1
Crossover Claims Only 1500	228	20
Dentist	8,234	4,011
Dentist, Group Practice	7,074	3,590
Dentist, Waiver	0	0
Doctor Of Osteopathy	48	22
DOULA	1	1
DOULA Group	16	3
Dual, Special Needs Plan	0	0
Durable Medical Equipment	6,045	2,192
Early Intervention	0	0
EPD Waiver	6	2
General Non-Billing	96	50
Group Applied Behavior Analyst	6	1
Hearing Aid Dealer	11	2
Hemodialysis, Freestanding	2,709	148
Home Health Agency	1,150	87
Hospice	30	10
Hospital, Emergency Access	4	3
Hospital, General	41,216	12,131
Hospital, LTAC	19	5
Hospital, Psychiatric Private	38	6
Hospital, Psychiatric Public	1	1
Housing Supportive Services	0	0
ICF/IDD	0	0
IDD Waiver	365	58
Ind Xray And Lab	0	0
Independent Lab	27,634	10,897
Independent Social Worker	72	39
Independent Social Worker Grp	197	35

**Alliance Adult and Child Utilization
FY2025**

Provider type description	Total paid claims	Total unique beneficiaries with at least one claim
Independent X-Ray	68	34
Lic Independ Clinical Social	0	0
Managed Care Organization	0	0
Marriage/Family Therapist	0	0
Marriage/Family Therapist Grp	0	0
MCO, Special Needs	2	1
Medical Transportation Broker	2,283	89
Mental Health Rehab Services	487	309
Nurse Midwives	38	19
Nurse Practitioner	836	331
Nursing Facility	27	16
Office State Superinten of Ed	0	0
Optician/Optical Dispensary	116	93
Optometrist	415	365
Optometrist Group	184	129
Participant Directed	0	0
Pharmacy, Institutional	18	4
Pharmacy, Retail	266,451	19,268
Physician Assistant	6	5
Physician MD	7,268	2,099
Physician, Group Practice	96,113	14,402
Podiatrist	90	31
Podiatry Group	114	63
Professional Counselor	0	0
Professional Counselor Group	286	14
Psychologist	0	0
Psychologist Group	2	1
Radiation Therapy Center	0	0
Recovery Support Services	0	0
Rehabiliataion Center	1,521	233
Residential Treatment Center	0	0
School Based ORP	0	0
Schools, DC Public	0	0
Schools, DC Public Charter	0	0
TOTAL UNIQUE	559,219	26,185

Source: DHCF Medicaid Management Information System (MMIS) data extracted January 13, 2026.

Notes: Reflects claims by date of service.

Includes non-capitation, non-FQHC wrap claims paid by managed care plans and DHCF for Alliance adults age 21+ and Beginning with FY 2026, Alliance services are paid by DHCF under fee-for-service. Prior to this date, most services for

**Alliance Adult and Child Utilization
FY2026 Q1**

Provider type description	Total paid claims	Total unique beneficiaries with at least one claim
Adult Day Care	0	0
Adult Day Health 1915(i)	0	0
Adv Practice Registered Nurse	0	0
Ambulance, Air Transport	0	0
Ambulance, Private	115	34
Ambulance, Public	112	94
Ambulatory Surgical Centers	6	6
Audiologist	0	0
Behavioral Hlth Stabilization	0	0
Birthing Centers	0	0
Clinic, Adlt Alc/Subst Abuse	0	0
Clinic, Dental	0	0
Clinic, Family Planning	0	0
Clinic, Fed Qualified Health	9,467	4,971
Clinic, Mental Health	20	1
Clinic, Private	75	5
Clinic, Youth Alc/Subst Abuse	0	0
Crossover Claims Only 1500	0	0
Dentist	87	58
Dentist, Group Practice	598	463
Dentist, Waiver	0	0
Doctor Of Osteopathy	0	0
DOULA	0	0
DOULA Group	2	1
Dual, Special Needs Plan	0	0
Durable Medical Equipment	1,410	935
Early Intervention	0	0
EPD Waiver	0	0
General Non-Billing	0	0
Group Applied Behavior Analyst	0	0
Hearing Aid Dealer	0	0
Hemodialysis, Freestanding	2,717	107
Home Health Agency	110	6
Hospice	0	0
Hospital, Emergency Access	15	7
Hospital, General	6,680	3,290
Hospital, LTAC	1	1
Hospital, Psychiatric Private	0	0
Hospital, Psychiatric Public	0	0
Housing Supportive Services	0	0
ICF/IDD	0	0
IDD Waiver	59	2
Ind Xray And Lab	0	0
Independent Lab	864	669
Independent Social Worker	0	0
Independent Social Worker Grp	2	2

15,308

7,601

685

521

**Alliance Adult and Child Utilization
FY2026 Q1**

Provider type description	Total paid claims	Total unique beneficiaries with at least one claim
Independent X-Ray	3	2
Lic Independ Clinical Social	0	0
Managed Care Organization	0	0
Marriage/Family Therapist	0	0
Marriage/Family Therapist Grp	0	0
MCO, Special Needs	0	0
Medical Transportation Broker	2	1
Mental Health Rehab Services	0	0
Nurse Midwives	2	2
Nurse Practitioner	91	50
Nursing Facility	0	0
Office State Superinten of Ed	0	0
Optician/Optical Dispensary	1	1
Optometrist	2	1
Optometrist Group	0	0
Participant Directed	0	0
Pharmacy, Institutional	0	0
Pharmacy, Retail	32,023	5,897
Physician Assistant	0	0
Physician MD	396	99
Physician, Group Practice	14,192	3,991
Podiatrist	0	0
Podiatry Group	0	0
Professional Counselor	0	0
Professional Counselor Group	5	2
Psychologist	0	0
Psychologist Group	0	0
Radiation Therapy Center	0	0
Recovery Support Services	0	0
Rehabiliataion Center	36	5
Residential Treatment Center	0	0
School Based ORP	0	0
Schools, DC Public	0	0
Schools, DC Public Charter	0	0
TOTAL UNIQUE	69,093	10,318

‡ Alliance children under age 21 who were formerly in the Immigrant Children's Program (ICP).
Alliance beneficiaries were delivered under managed care plans.

44. For FY 2025, and FY 2026, to date, please provide the following data for the Alliance program:

- a. Monthly enrollment data;**
- b. Monthly spending on services; and**
- c. Utilization of services, broken down by service type.**

Response:

Enrollment information is available on the DHCF website at <https://dhcf.dc.gov/node/1180991>.

For expenditures associated with the Alliance program, please see the response to Question 25.

For utilization data, please see Attachment 1 to Q44.

45. In FY 2025 and FY 2026, to date, what was the:

- a. Average length of time for renewal of Alliance benefits;**
- b. Average length of time to match an Alliance beneficiary with an MCO after they were deemed eligible (in FY 2025 only);**
- c. Number and rate of Alliance beneficiaries whose benefits were not renewed due to changes in eligibility; and**
- d. Number and rate of Alliance customers whose benefits were not renewed for procedural reasons.**

Response:

- a. See column 5 below for the average length of time in days to process Alliance non-passive renewals among those processed with available dates. Renewals in column 6 are a subset of column 2 and are not included in column 5 because they are missing either the responded date or the completed date. Passive renewals are omitted from the table because the processing is automated; no action is required on the part of a beneficiary or caseworker to complete the renewal.

1	2	3	4	5	6
Recertification Date	Alliance non-passive renewals that were processed (3+4)	Non-passive renewals determined eligible	Non-passive renewals determined ineligible	Average length of time (in days) to process Alliance renewals	Number of Alliance renewals that were processed with an unknown date
Number of beneficiaries					
10/31/2024	241	186	55	12	70
11/30/2024	191	140	51	0	59
12/31/2024	263	195	68	7	63
1/31/2025	98	74	24	9	31
2/28/2025	18	14	4	9	4
3/31/2025	82	73	9	14	13
4/30/2025	636	571	65	10	127
5/31/2025	485	448	37	14	80
6/30/2025	490	453	37	17	79
7/31/2025	607	545	62	22	89
8/31/2025	623	565	58	26	119
9/30/2025	680	557	123	22	131
10/31/2025	1,232	1,063	169	21	177
11/30/2025	723	623	100	21	122
12/31/2025	525	422	103	6	62
Percent of the processed					
10/31/2024	100%	77%	23%	N/A	29%
11/30/2024	100%	73%	27%	N/A	31%
12/31/2024	100%	74%	26%	N/A	24%

1	2	3	4	5	6
Recertification Date	Alliance non-passive renewals that were processed (3+4)	Non-passive renewals determined eligible	Non-passive renewals determined ineligible	Average length of time (in days) to process Alliance renewals	Number of Alliance renewals that were processed with an unknown date
1/31/2025	100%	76%	24%	N/A	32%
2/28/2025	100%	78%	22%	N/A	22%
3/31/2025	100%	89%	11%	N/A	16%
4/30/2025	100%	90%	10%	N/A	20%
5/31/2025	100%	92%	8%	N/A	16%
6/30/2025	100%	92%	8%	N/A	16%
7/31/2025	100%	90%	10%	N/A	15%
8/31/2025	100%	91%	9%	N/A	19%
9/30/2025	100%	82%	18%	N/A	19%
10/31/2025	100%	86%	14%	N/A	14%
11/30/2025	100%	86%	14%	N/A	17%
12/31/2025	100%	80%	20%	N/A	12%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: All columns in the table increase for those due in April 2025 and beyond due to eligibility system changes that require most Alliance beneficiaries to actively respond to a renewal notice in order to retain coverage. Renewals in column 6 are a subset of column 2 and are not included in column 5 because they are missing either the responded date or completed date, and therefore a length of time cannot be calculated.

- b. Once an Alliance beneficiary's eligibility is determined in DCAS, a record of their eligibility is transmitted to DHCF's Medicaid Management Information System (MMIS). Assignment to an MCO is generally immediate or within one day.

The MMIS will immediately assign beneficiaries to their previous MCO for up to 90 days retroactive if their eligibility is reinstated back to the date of a coverage loss (e.g., if an individual did not renew their coverage timely but did respond during the grace period); this process is referred to as provider continuity. The MMIS otherwise sends a daily file to DHCF's MCO enrollment broker for immediate auto-assignment of Alliance beneficiaries who are first-time eligibles or re-enrolling after a longer coverage gap; beneficiaries have 90 days to choose and transfer to an alternative MCO if desired.

As of FY 2026, Alliance beneficiaries receive coverage under a fee-for-service model, so the MCO assignment process is no longer applicable.

- c. See column 3 below.
- d. See column 4 below.

1	2	3	4
Recertification Date	Alliance beneficiaries receiving a non-passive renewal notice who were disenrolled at renewal (3+4)	Non-passive renewals determined ineligible	Non-passive renewals procedurally terminated
Number of beneficiaries			
10/31/2024	154	55	99
11/30/2024	145	51	94
12/31/2024	176	68	108
1/31/2025	63	24	39
2/28/2025	16	4	12
3/31/2025	67	9	58
4/30/2025	675	65	610
5/31/2025	561	37	524
6/30/2025	616	37	579
7/31/2025	728	62	666
8/31/2025	790	58	732
9/30/2025	940	123	817
10/31/2025	1,286	169	1,117
11/30/2025	1,309	100	1,209
12/31/2025	1,979	103	1,876
Percent of the disenrolled			
10/31/2024	100%	36%	64%
11/30/2024	100%	35%	65%
12/31/2024	100%	39%	61%
1/31/2025	100%	38%	62%
2/28/2025	100%	25%	75%
3/31/2025	100%	13%	87%
4/30/2025	100%	10%	90%
5/31/2025	100%	7%	93%
6/30/2025	100%	6%	94%
7/31/2025	100%	9%	91%
8/31/2025	100%	7%	93%
9/30/2025	100%	13%	87%
10/31/2025	100%	13%	87%
11/30/2025	100%	8%	92%
12/31/2025	100%	5%	95%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: All columns in the table increase for those due in April 2025 and beyond due to eligibility system changes that require most Alliance beneficiaries to actively respond to a renewal notice in order to retain coverage.

Q46.

Please describe the process that an Alliance enrollee who become pregnant and qualifies for Medicaid coverage would need to take. Please include:

- a) Who the enrollee would need to inform;**
- b) What forms they may need to complete, and within what specified time frame;**
- c) Income requirements;**
- d) Services an enrollee can expect during the pregnancy and post-partum period including length of coverage;**
- e) How DHCF will notify the enrollee that their coverage is ending; and**
- f) What coverage is available to both the parent and their child after pregnancy-related Medicaid coverage ends.**

Response

District of Columbia Medicaid provides **two** types of medical coverage to pregnant individuals with income up to 319% of the federal poverty level (FPL) plus a 5% income disregard. **CHIP From Conception to End of Pregnancy** (previously known as Unborn Child) and **Medicaid** for pregnant individuals. See eligibility criteria below:

CHIP From-Conception-to-End-of-Pregnancy (FCEP)

- Pregnant
- DC Resident
- Regardless of immigration status
- Meet income requirements (319% FPL)
- Not enrolled or eligible for Medicaid or Medicare

Medicaid Program

- Pregnant
- DC Resident
- US Citizen or eligible immigration status
- Meet income requirements (319% FPL)

Each eligibility category provides comprehensive coverage, including care related to the pregnancy, labor, and delivery and any complications that may occur during pregnancy, as well as post-partum care which begins on the date the pregnancy ends. CHIP From Conception to End of Pregnancy offers an additional **two (2) months** post-partum care, and Medicaid offers an additional **twelve (12) months** of post-partum care.

Once the birth is reported, the child will automatically enroll in Medicaid until their first birthday, at which time they will need to be redetermined for Medicaid eligibility.

Current Alliance/Medicaid enrollees need to report a change of circumstances to be enrolled in CHIP From Conception to End of Pregnancy/Medicaid for Pregnant Individuals. Residents can

report your pregnancy through all available methods, such as District Direct, phone, fax, mail or in-person. Beneficiaries are to report that they are pregnant and the expected due date (or date of conception). No additional verification is needed.

Residents who are not currently enrolled in a DHCF administered program need to apply to be determined eligible. Residents can apply for health coverage through District Direct, phone, fax, mail or in person. If eligible, coverage will begin the first month of application.

Once coverage ends, residents will be redetermined for alternative coverage under Alliance or Medicaid. If the resident qualifies for additional coverage, they will receive notice altering them to a change in eligibility. If the resident does not qualify for further coverage, they will receive a notice of adverse action. Residents over the age of 26 who applied after October 1, 2025 are not eligible for enrollment into the Alliance program due to the enrollment moratorium.

**DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

General Question

47. Please describe how DHCF is working with DBH to transition Alliance beneficiaries out of coverage who are losing access to critical behavioral health and substance use services like ACT teams, and what coverage will still be covered locally.

Response:

Community-based behavioral health services [like mental health rehabilitative services (MHRS) and substance use disorder services] are funded through the Department of Behavioral Health (DBH) for residents enrolled in the Alliance program.

Beginning October 1, 2025, Alliance beneficiaries who are over 138% of the federal poverty level (FPL) are no longer eligible for the Alliance program. DBH does not fund behavioral health services for this population with some exceptions. The exceptions include: ACT and crisis response services, CPEP, the stabilization center and DBH walk-in clinics, which are available to residents. Former Alliance beneficiaries who were over 138% of the FPL and are undocumented may be able to access Medicaid reimbursed mental or behavioral health services under Emergency Medicaid if the episode qualifies for emergent under the policy. Residents may also be able to access services through community-based service providers like FQHCs at low/no cost depending on their income.

48. How many beneficiaries were in the middle any type of any type of care or treatment plan in FY 2025 who lost Alliance coverage in FY 2026 that DHCF extended benefits to cover care?

- a. Please share the number of beneficiaries per treatment category (for examples, Cancer care, oral surgery, substance use treatment, treatment for a serious mental illness, etc.) and how long coverage was extended.**

Response:

Benefit/Service	Number of beneficiaries	MCO benefit or Value Add
Chiropractic	1	Value Add
Dental	5	MCO
Hearing	0	MCO
Home Health	6	MCO
Infusion	1	
NEMT*	0	MCO
Podiatry	0	MCO
Skilled Nursing- Rehab	0	MCO
Vision(optometry/glasses)	0	MCO

* NEMT-non emergent transportation

Dental coverage was extended to cover patients until the completion of their treatment

Home health Hospice, Skilled Nursing-Rehab, podiatry, hearing, vision were afforded a 30 day bridge until October 30th to complete any treatment in progress. These are the only benefits which were terminated as of October 1, 2026. Non emergent transportation was not extended for 30 days since it was a benefit only offered by the managed care plans.

49. Please detail all software upgrades made to the DC Access System (DCAS) in FY 2025 and FY 2026, to date, including the date of the upgrade, the problem being addressed, and the status of the upgrade (completed, pending, paused, etc.)

Response:

Project	Purpose	Date	Status
OHS/ODU Upgrade to v12.2.1.4	To address security updates and enhance system stability	Jan 1st, 2024	Completed
Upgrade Curam from v7.0.11.0_iFix3 to v8.1.1.0	To ensure compliance with Merative releases and integration with other compliant systems.	July 7th 2024	Completed
Upgrade Weblogic Server from 12.2.1.4 to 14.1.1.0	To support Curam Product upgrade and enhance system stability	July 7th 2024	Completed
Informatica Upgrade 10.4.1 to 10.5.5	The upgrade to Informatica V10.5.5 will enhance system stability, reduce processing errors, and improve data exchange efficiency with external agencies such as SSA, CMS, and IRS. This leads to optimized operations, minimizing delays, and ensuring compliance with data-sharing standards, offering long-term operational savings and improved service reliability.	June 8th 2024	Completed
Batch Scheduler Migration (Control M)	Transition batch scheduling operations from UC4 to Control-M, enhancing job scheduling efficiency, monitoring, and automation capabilities.	March 05th, 2025	Completed
Mongo DB Upgrade v7.0.0.8	To enhance performance, security, and access to new features and to keep up with vendor EOL dates.	Aug 15th, 2025	Completed
AWS Cloud Migration	Migrate the DCAS (Curám) application from an on-premises environment to AWS Cloud to enhance scalability, flexibility, and performance.	Sep 01st, 2025	Completed
RHEL Upgrade 7.9 to 8.10	To access improved performance, enhanced security, and the latest features while extending hardware life and modernizing the environment.	Sep 01st, 2025	Completed
Migrate to OCTO Cloud Splunk v9.3.2411.121	To monitor security, including threat detection and fraud as well as Security Information and Event Management (SIEM) activity.	Sep 01st, 2025	Completed

Oracle IAM Upgrade & Migration	Enhance and modernize the Oracle Identity and Access Management (OIAM) environment through a comprehensive upgrade and migration.	Dec 21st, 2025	Completed

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Response:

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Department of Health Care Finance
Performance Oversight Hearing
Q50 DCAS Information Technology Management Division
Budget vs Expenditure

Cost Center (Parent Level 1)	Cost Center (Parent Level 1) Description	Cost Center Description	Account	Account Description	FY2025			FY2026 (Thru December)				
					Total Budget	Expenditure	Available Budget	Total Budget	Commitment	Obligation	Expenditure	Available Budget
H2901	DCAS PROGRAM MANAGEMENT ADMINISTRATION	Various	7132002	IT CONSULTANT CONTRACTS	40,352,750	38,381,827	1,970,923	37,960,383	-	6,215,701	6,904,373	24,840,310
H2901	DCAS PROGRAM MANAGEMENT ADMINISTRATION	70153	7171008	IT HARDWARE ACQUISITIONS	73,735	-	73,735	166,251	-	-	-	-
H2901	DCAS PROGRAM MANAGEMENT ADMINISTRATION	Various	7171009	IT SOFTWARE ACQUISITIONS	12,202,771	11,720,855	481,917	11,430,883	1,479,593	357,700	475,824	9,117,766
Grand Total					52,629,257	50,102,681	2,526,575	49,557,517	1,479,593	6,573,401	7,380,197	33,958,075

50. Please provide spending/costs, both actual and projected, for FY 2025 and FY 2026, to date, for Information Technology Management, broken down by IT equipment and IT contracts.

Response:

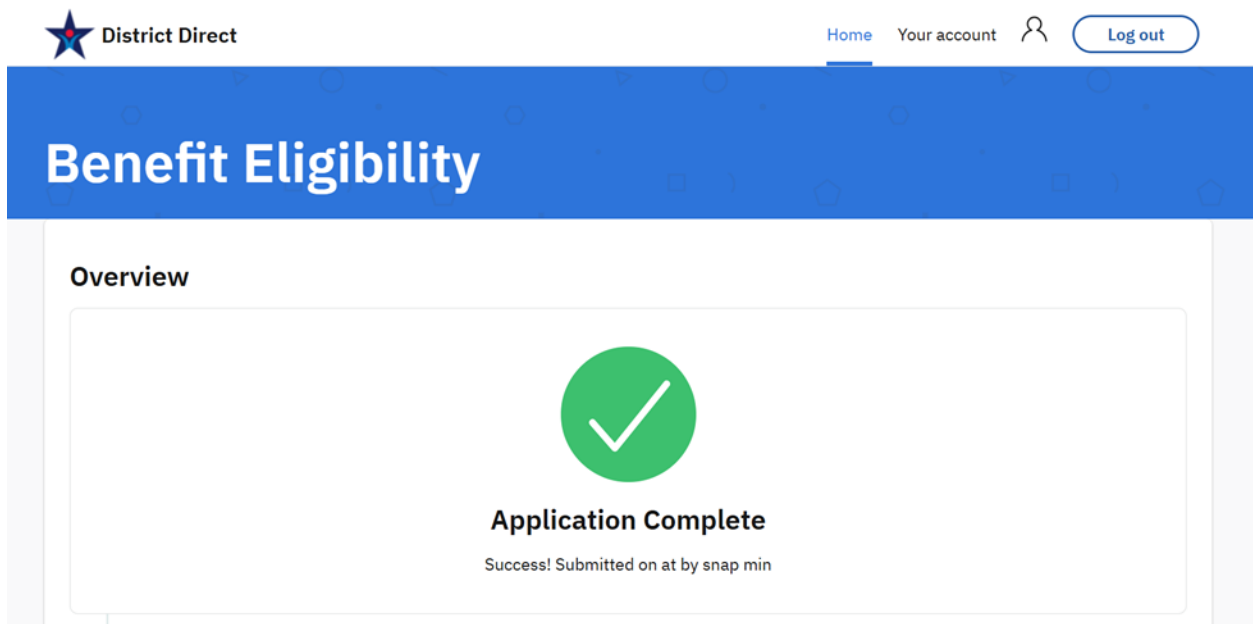
Please see Q50 Attachment

51. Please provide the steps DHCF has taken in FY 2024 and FY 2025, to date, to address the following common complaints about the DCAS application system:

- a. No confirmation of completed application.**
- b. Benefits cut off when a completed application is pending**

Response:

- a. Currently, residents who complete an online or mobile application will receive confirmation that their application was submitted successfully. At the end of your submission, you will see a confirmation screen. See screenshot below.



You may also view this information in “Applications Summary” section on the home screen and can download your application in a pdf format, using the blue, download arrow, as seen in the visual below:

Application Summary

The dashboard information reflects your latest applications. Click [View Details](#) to view all your applications.

0 Application 

You have no application in progress.

2 Program Requested 

You have 2 programs requested.

1 Application PDF 

You have 1 submitted applications.

[View Details](#)

My Applications

Applications In-Progress

You have no applications in-progress at this time.

Submitted Applications

Medical Assistance, SNAP
Date Submitted: 1/28/2025



Response:

- b. DHCF provides DHS with a report that identifies cases that are ready to be processed to further assist ESA with timely processing. As result clients who may have submitted their recertifications late or in the grace period can continue their benefits vs. submitting subsequent applications.

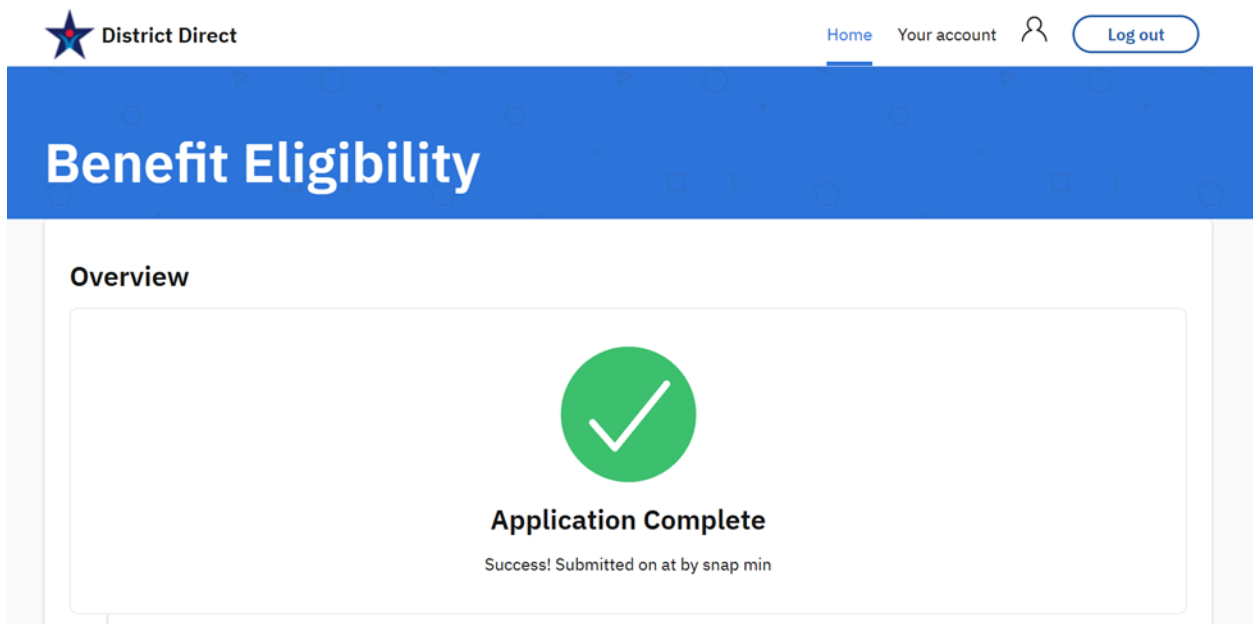
If a resident submits a renewal (or application within renewal cycle) through District Direct online, DCAS will identify those renewals/applications, so that the case will remain eligible until a determination is made by a caseworker. In addition, DHCF provides DHS with a report that identifies cases ready for processing to ensure applications that were submitted late or in the grace period are not terminated.

51. Please provide the steps DHCF has taken in FY 2024 and FY 2025, to date, to address the following common complaints about the DCAS application system:

- a. No confirmation of completed application.**
- b. Benefits cut off when a completed application is pending**

Response:

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Application Summary

The dashboard information reflects your latest applications. Click [View Details](#) to view all your applications.

0 Application 

You have no application in progress.

2 Program Requested 

You have 2 programs requested.

1 Application PDF 

You have 1 submitted applications.

[View Details](#)

My Applications

Applications In-Progress

You have no applications in-progress at this time.

Submitted Applications

Medical Assistance, SNAP
Date Submitted: 1/28/2025



Response:

- b. DHCF provides DHS with a report that identifies cases that are ready to be processed to further assist ESA with timely processing. As result clients who may have submitted their recertifications late or in the grace period can continue their benefits vs. submitting subsequent applications.

If a resident submits a renewal (or application within renewal cycle) through District Direct online, DCAS will identify those renewals/applications, so that the case will remain eligible until a determination is made by a caseworker. In addition, DHCF provides DHS with a report that identifies cases ready for processing to ensure applications that were submitted late or in the grace period are not terminated.

52. Please describe how DCAS used Amazon Web Services in FY 2025 and FY 2026, to date.

Response:

DCAS leverages Amazon Web Services (AWS) cloud infrastructure to host and operate DCAS environments previously maintained on on-premises systems. This cloud modernization enables us to support more scalable and resilient system operations, a faster response to policy or programmatic changes, and improved system performance during peak demand periods, including centralized management of production, testing and development environments.

In addition, AWS supports our security and compliance framework, including encryption, access controls, and continuous monitoring, strengthening DCAS's alignment with federal and District security requirements.

53. For Medicaid enrollees required to renew manually in FY 2025 and FY 2026 to date, please provide, broken out by month:

- a. The number and percentage of enrollees that returned renewal forms prior to the end of their certification period;**
- b. The number and percentage of enrollees that were terminated for failure to manually renew prior to end of their certification period; and**
- c. The number and percentage of enrollees 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:

The table below reflects Medicaid enrollees required to renew manually (i.e., non-passively) in FY 2025 and FY 2026 YTD.

- a. See column 3 below. Most individuals who returned a renewal form prior to their certification date would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was included to highlight additional individuals who retain coverage despite not returning a form prior to their certification date. This includes non-MAGI (Modified Adjusted Gross Income) beneficiaries through the March 2025 cohort who responded during their one-month extension. The one-month extension stopped with the April 2025 cohort. Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.
- b. See column 4 below. This group reflects MAGI beneficiaries terminated at their certification date and non-MAGI beneficiaries terminated after a one-month extension through the March 2025 cohort. Beginning with the April 2025 cohort, all beneficiaries are terminated at their certification date because the one-month extension for non-MAGI beneficiaries ended.
- c. See column 6 below. This group is a subset of column 4 and reflects MAGI beneficiaries terminated at their certification date and non-MAGI beneficiaries through the March 2025 cohort terminated after the one-month extension who returned a renewal form during their 90-day grace period. Beginning with the April 2025 cohort, all beneficiaries are terminated at their certification date because the one-month extension for non-MAGI beneficiaries ended.

Medicaid Beneficiaries Receiving Non-Passive Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	Total receiving non-passive renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification n period but reinstated or never terminated	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 (subset of 4)	
Number of beneficiaries						
2024-10-31*	5,350	3,113	1,577	56	990	604
2024-11-30*	4,479	2,425	1,493	63	907	498
2024-12-31*	3,703	1,879	1,440	15	729	369
2025-01-31*	2,713	1,407	988	21	536	297
2025-02-28*	2,653	1,418	925	40	444	270
2025-03-31*	3,136	1,845	1,190	36	631	65
2025-04-30	6,243	3,118	3,096		1,495	29
2025-05-31	4,601	2,308	2,280		895	13
2025-06-30	5,804	2,968	2,791		1,293	45
2025-07-31	6,906	3,756	3,116		1,393	34
2025-08-31	6,166	3,392	2,728		1,374	46
2025-09-30	2,905	1,553	1,346		523	6
2025-10-31	3,810	2,067	1,733		666	10
2025-11-30	4,078	2,075	1,990		569	13
2025-12-31	4,614	2,029	2,575		35	10
Percent of total receiving non-passive renewal form						
2024-10-31*	100%	58%	29%	1%	19%	11%
2024-11-30*	100%	54%	33%	1%	20%	11%
2024-12-31*	100%	51%	39%	0%	20%	10%
2025-01-31*	100%	52%	36%	1%	20%	11%
2025-02-28*	100%	53%	35%	2%	17%	10%

1	2	3	4	5	6	7
Recertification Date	Total receiving non-passive renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but reinstated or never terminated	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 (subset of 4)	
2025-03-31*	100%	59%	38%	1%	20%	2%
2025-04-30	100%	50%	50%		24%	0%
2025-05-31	100%	50%	50%		19%	0%
2025-06-30	100%	51%	48%		22%	1%
2025-07-31	100%	54%	45%		20%	0%
2025-08-31	100%	55%	44%		22%	1%
2025-09-30	100%	53%	46%		18%	0%
2025-10-31	100%	54%	45%		17%	0%
2025-11-30	100%	51%	49%		14%	0%
2025-12-31	100%	44%	56%		1%	0%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

* Due to a system process implemented to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated), renewal outcomes for these months are updated prior to the beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to many renewals with unknown dates, and we are unable to determine the columns to which they belong in the table.

Column-specific notes are provided below.

- Column 3 includes a small number of beneficiaries who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included (through the 3/2025 cohort).
- Column 4 reflects MAGI beneficiaries terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension (through the 3/2025 cohort).
- Column 5 includes non-MAGI beneficiaries who responded during their one-month extension (through the 3/2025 cohort) and becomes zero starting in April 2025 when the one-month extension ended.
- Column 6 is a subset of column 4 and reflects MAGI beneficiaries terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period (through the 3/2025 cohort). These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS)

until their renewal is processed; most are ultimately determined eligible, but a small number are determined ineligible and disenrolled. The grace period for October 2025 and later cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.

- Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

54. For enrollees who were terminated for procedural reasons in FY 2025 and FY 2026, to date, please provide:

- a. The number of applications submitted during the grace period, including the average number of days into the grace period the application was submitted;**
- b. The number of enrollees who were without coverage for a period of time and subsequently filed a new application within the same year, including the number of days the individual was without coverage; and**
- c. 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:

See column 2 of table below for the number of beneficiaries terminated for procedural reasons (i.e., failure to manually renew prior to the end of their certification period). This group reflects MAGI (Modified adjusted gross income) beneficiaries terminated at their certification date. It reflects non-MAGI beneficiaries in a cohort through March 2025 terminated after a one-month extension and non-MAGI beneficiaries in a cohort starting in April 2025 or later terminated at their certification date because the one-month extension ended. The table reflects Medicaid enrollees required to renew in FY 2025 and FY 2026 YTD.

- a. See column 3 of the table below for the number of individuals who returned a renewal form during their 90-day grace period, which is a subset of column 2. Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available. Column 5 provides the average number of days into the grace period the renewal form was submitted.
- b. See column 3 for the number of individuals who were without coverage for a period of time and subsequently filed a renewal within the 90-day grace period.
- c. See column 4 of the table below for the number of individuals who did not return a renewal form during their 90-day grace period, which is a subset of column 2.

Medicaid Beneficiaries Terminated for Failure to Manually Review and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6
Recertification Date	Date of renewal received is known				Renewal received with an unknown date
	Terminated for failure to manually renew prior to the end of their certification period	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	Lost coverage at the end of their certification period and were not able to regain coverage during the 90-day grace period following the end of their certification period	Average number of days into the grace period the renewal was submitted	
Number of beneficiaries					
2024-10-31*	1,577	990	587	57	604
2024-11-30*	1,493	907	586	40	498
2024-12-31*	1,440	729	711	37	369
2025-01-31*	988	536	452	32	297
2025-02-28*	925	444	481	32	270
2025-03-31*	1,190	631	559	29	65
2025-04-30	3,096	1,495	1,601	32	29
2025-05-31	2,280	895	1,385	32	13
2025-06-30	2,791	1,293	1,498	28	45
2025-07-31	3,116	1,393	1,723	29	34
2025-08-31	2,728	1,374	1,354	27	46
2025-09-30	1,346	523	823	27	6
2025-10-31	1,733	666	1,067	22	10
2025-11-30	1,990	569	1,421	13	13
2025-12-31	2,575	35	2,540	2	10
Percent of total terminated for failure to manually renew prior to certification end					
2024-10-31*	100%	63%	37%	N/A	N/A
2024-11-30*	100%	61%	39%	N/A	N/A
2024-12-31*	100%	51%	49%	N/A	N/A
2025-01-31*	100%	54%	46%	N/A	N/A
2025-02-28*	100%	48%	52%	N/A	N/A
2025-03-31*	100%	53%	47%	N/A	N/A
2025-04-30	100%	48%	52%	N/A	N/A
2025-05-31	100%	39%	61%	N/A	N/A

2025-06-30	100%	46%	54%	N/A	N/A
2025-07-31	100%	45%	55%	N/A	N/A
2025-08-31	100%	50%	50%	N/A	N/A
2025-09-30	100%	39%	61%	N/A	N/A
2025-10-31	100%	38%	62%	N/A	N/A
2025-11-30	100%	29%	71%	N/A	N/A
2025-12-31	100%	1%	99%	N/A	N/A

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal. NA is not applicable. Column- specific notes are provided below.

- * Due to a system process implemented to ensure that renewals are fully recognized in DCAS (which allows future renewals to be initiated), renewal outcomes for these months are updated prior to a beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to a large number of renewals with unknown dates, and we are unable to determine the columns to which they belong in the table.
- Column 2 reflects MAGI beneficiaries terminated at their certification date and non-MAGI beneficiaries terminated after the one-month extension (through the 3/2025 cohort).
- Column 3 is a subset of column 2 and reflects individuals who returned a renewal form during their 90-day grace period. These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible, but a small number are determined ineligible and disenrolled. The grace period for October 2025 and later cohorts is incomplete and we expect the number of beneficiaries to regain coverage from these groups to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.
- Column 4 is a subset of column 2 and reflects individuals who did not return a renewal form during their 90-day grace period.
- Column 5 reflects the date that the beneficiary filed the renewal with the District.
- Column 6 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

55. Regarding renewal notices:

- a. Of Medicaid enrollees who have been required to renew manually in FY 2025 and FY 2026, 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 DHCF has encountered in sending notices to Medicaid recipients in FY 2025 and FY 2026, to date, and any steps DHCF is taking to address these issues.

Response:

- a. See table below. It reflects Medicaid enrollees required to renew manually (i.e., non-passively) in FY 2025 and FY 2026 YTD.

Medicaid Beneficiaries Receiving Non-Passive Renewal Form by Pre-Populated Status, FY 2025 and FY 2026 to Date

Recertification Date	Total receiving non-passive renewal form	Number of beneficiaries who received pre-populated renewal forms no later than 60 or 90 days prior to the end of their certification	MAGI beneficiaries who received pre-populated renewal forms	Non-MAGI beneficiaries who received pre-populated renewal forms
2024-10-31	5,350	4,951	3,782	1,169
2024-11-30	4,479	4,270	3,599	671
2024-12-31	3,703	3,652	3,387	265
2025-01-31	2,713	2,700	2,446	254
2025-02-28	2,653	2,536	2,154	382
2025-03-31	3,136	3,009	2,584	425
2025-04-30	6,243	6,138	5,713	425
2025-05-31	4,601	4,495	4,019	476
2025-06-30	5,804	5,780	5,178	602
2025-07-31	6,906	6,864	6,257	607
2025-08-31	6,166	6,102	5,512	590
2025-09-30	2,905	2,860	2,262	598
2025-10-31	3,810	3,616	3,290	326
2025-11-30	4,078	3,945	2,770	1,175
2025-12-31	4,614	4,547	4,065	482

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: The number of beneficiaries required to submit the conversion form declined substantially since the first year of the renewal restart but are still required for some beneficiaries due to additional information required for a determination (e.g., beneficiaries gaining Medicare coverage).

- b. Medicaid beneficiaries receive renewals 60 to 90 days in advance of their renewal end date. There were no issues with generating the 60- or 90-day advance renewal notices in FY 2025 or FY 2026 to date. These notices are generated in advance with validation

controls in place to ensure timely and accurate delivery.

57. For the Aged, Blind, and Disabled (“ABD”) Medicaid population, how many enrollees on a monthly basis were passively renewed, and how many were sent a renewal form in FY 2025 and in FY 2026, to date?

- a. For the ABD population that was sent a renewal form, how many were sent the Conversion Renewal Form, and how many as a raw number and percentage of the overall were sent the Non-MAGI Renewal Form in FY 2025 and in FY 2026, to date?**
- b. For the ABD population that was sent the Conversion Renewal Form, how many returned that form before the termination of their Medicaid coverage? And how many returned the form after the termination of their coverage but within the 90-day grace period in FY 2025 and in FY 2026, to date?**
- c. For the ABD population that was sent the non-MAGI Renewal Form, how many returned that form before the termination of their Medicaid coverage? And how many returned the form after the termination of their coverage but within the 90-day grace period in FY 2025 and in FY 2026, to date?**
- d. How many ABD enrollees lost coverage in FY 2025 and FY 2026 due to increased income?**

Response:

For Aged, Blind, and Disabled (ABD) beneficiaries passively renewed and those required to submit a non-passive renewal form, see columns 3 and 4 of the table under item a below. The table reflects Medicaid enrollees required to renew in FY 2025 and FY 2026 YTD.

- a. See columns 5 and 6 below.

Medicaid ABD Beneficiaries Due for Renewal by Passively Renewed and Non-Passive Renewal Form Type, FY 2025 and FY 2026 to Date

1	2	3	4	5	6
Recertification Date	ABD beneficiaries due for renewal	ABD beneficiaries passively renewed	ABD beneficiaries receiving non-passive renewal form	ABD beneficiaries required to complete the conversion form	ABD beneficiaries required to complete the non-MAGI form
Number of beneficiaries					
2024-10-31	14,401	14,065	336	82	254
2024-11-30	2,416	2,030	386	113	273
2024-12-31	1,555	1,476	79	20	59
2025-01-31	664	615	49	3	46
2025-02-28	1,118	960	158	50	108
2025-03-31	1,014	824	190	66	124
2025-04-30	1,436	1,282	154	47	107
2025-05-31	1,389	1,223	166	52	114
2025-06-30	848	718	130	10	120

1	2	3	4	5	6
Recertification Date	ABD beneficiaries due for renewal	ABD beneficiaries passively renewed	ABD beneficiaries receiving non-passive renewal form	ABD beneficiaries required to complete the conversion form	ABD beneficiaries required to complete the non-MAGI form
2025-07-31	870	754	116	13	103
2025-08-31	1,549	1,377	172	14	158
2025-09-30	1,376	1,193	183	18	165
2025-10-31	11,906	11,810	96	12	84
2025-11-30	2,235	1,930	305	14	291
2025-12-31	1,707	1,529	178	6	172
Percent of total due for renewal					
2024-10-31	100%	98%	2%	1%	2%
2024-11-30	100%	84%	16%	5%	11%
2024-12-31	100%	95%	5%	1%	4%
2025-01-31	100%	93%	7%	0%	7%
2025-02-28	100%	86%	14%	4%	10%
2025-03-31	100%	81%	19%	7%	12%
2025-04-30	100%	89%	11%	3%	7%
2025-05-31	100%	88%	12%	4%	8%
2025-06-30	100%	85%	15%	1%	14%
2025-07-31	100%	87%	13%	1%	12%
2025-08-31	100%	89%	11%	1%	10%
2025-09-30	100%	87%	13%	1%	12%
2025-10-31	100%	99%	1%	0%	1%
2025-11-30	100%	86%	14%	1%	13%
2025-12-31	100%	90%	10%	0%	10%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: See notes applicable to all tables at the end of this document.

- b. See column 3 below for the number of Medicaid ABD beneficiaries who returned a conversion renewal form before the termination of their Medicaid coverage. Most of these individuals would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was included to highlight additional individuals who retain coverage despite not returning a form prior to their certification date, reflecting non-MAGI beneficiaries who responded during their one-month extension. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

See column 6 for the number who returned the form after the termination of their coverage but within the 90-day grace period. This group is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

Medicaid ABD Beneficiaries Receiving Conversion Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	ABD beneficiaries required to complete the conversion renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but never terminated	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 (subset of 4)	
Number of beneficiaries						
2024-10-31*	82	54	21	1	5	6
2024-11-30*	113	52	34	15	7	12
2024-12-31*	20	6	9	1	1	4
2025-01-31*	3	2	0	1	0	0
2025-02-28*	50	24	19	5	5	2
2025-03-31*	66	30	19	5	9	12
2025-04-30	47	25	22		13	0
2025-05-31	52	32	20		11	0
2025-06-30	10	4	6		4	0
2025-07-31	13	8	5		4	0
2025-08-31	14	7	7		3	0
2025-09-30	18	12	6		2	0
2025-10-31	12	7	5		4	0
2025-11-30	14	8	6		2	0
2025-12-31	6	4	2		0	0
Percent of total receiving conversion renewal form						
2024-10-31*	100%	66%	26%	1%	6%	7%
2024-11-30*	100%	46%	30%	13%	6%	11%
2024-12-31*	100%	30%	45%	5%	5%	20%
2025-01-31*	100%	67%	0%	33%	0%	0%
2025-02-28*	100%	48%	38%	10%	10%	4%
2025-03-31*	100%	45%	29%	8%	14%	18%
2025-04-30	100%	53%	47%		28%	0%

2025-05-31	100%	62%	38%		21%	0%
2025-06-30	100%	40%	60%		40%	0%
2025-07-31	100%	62%	38%		31%	0%
2025-08-31	100%	50%	50%		21%	0%
2025-09-30	100%	67%	33%		11%	0%
2025-10-31	100%	58%	42%		33%	0%
2025-11-30	100%	57%	43%		14%	0%
2025-12-31	100%	67%	33%		0%	0%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: See notes applicable to all tables at the end of this document.

- c. See column 3 below for the number of Medicaid ABD beneficiaries who returned a non-MAGI renewal form before the termination of their Medicaid coverage. Most of these individuals would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was included to highlight additional individuals who retain coverage despite not returning a form prior to their certification date, reflecting non-MAGI beneficiaries who responded during their one-month extension. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

See column 6 for the number who returned the form after the termination of their coverage but within the 90-day grace period. This group is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

Medicaid ABD Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	ABD beneficiaries required to complete the non-MAGI renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but never terminated	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 (subset of 4)	
Number of beneficiaries						

1	2	3	4	5	6	7
Recertification Date	ABD beneficiaries required to complete the non-MAGI renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but never terminated	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 (subset of 4)	
2024-10-31*	254	159	45	13	15	37
2024-11-30*	273	163	61	20	17	29
2024-12-31*	59	36	11	4	6	8
2025-01-31*	46	24	11	5	6	6
2025-02-28*	108	76	21	6	15	5
2025-03-31*	124	79	29	7	9	9
2025-04-30	107	73	34		20	0
2025-05-31	114	71	43		24	0
2025-06-30	120	67	53		24	0
2025-07-31	103	58	45		17	0
2025-08-31	158	105	53		26	0
2025-09-30	165	118	46		26	1
2025-10-31	84	56	28		8	0
2025-11-30	291	171	120		37	0
2025-12-31	172	89	81		0	2
Percent of total receiving non-MAGI renewal form						
2024-10-31*	100%	63%	18%	5%	6%	15%
2024-11-30*	100%	60%	22%	7%	6%	11%
2024-12-31*	100%	61%	19%	7%	10%	14%
2025-01-31*	100%	52%	24%	11%	13%	13%
2025-02-28*	100%	70%	19%	6%	14%	5%
2025-03-31*	100%	64%	23%	6%	7%	7%
2025-04-30	100%	68%	32%		19%	0%
2025-05-31	100%	62%	38%		21%	0%
2025-06-30	100%	56%	44%		20%	0%
2025-07-31	100%	56%	44%		17%	0%
2025-08-31	100%	66%	34%		16%	0%
2025-09-30	100%	72%	28%		16%	1%
2025-10-31	100%	67%	33%		10%	0%
2025-11-30	100%	59%	41%		13%	0%
2025-12-31	100%	52%	47%		0%	1%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: See notes applicable to all tables at the end of this document.

Notes applicable to tables that appear under responses to items b and c:

Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

* Due to a system process implemented to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated), renewal outcomes for these months are updated prior to a beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to a large number of renewals with unknown dates, and we are unable to determine the columns to which they belong in the table.

- Column 3 includes a small number of beneficiaries who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included (through the 3/2025 cohort).
 - Column 4 reflects non-MAGI beneficiaries terminated after the one-month extension (through the 3/2025 cohort).
 - Column 5 reflects non-MAGI beneficiaries who responded during their one-month extension (through the 3/2025 cohort) and becomes zero starting in April 2025 when the one-month extension ended.
 - Column 6 is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period (through the 3/2025 cohort). These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible, but a small number are determined ineligible and disenrolled. The grace period for October 2025 and later cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.
 - Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.
- d. DHCF does not have readily available data on coverage losses due to increased income. However, DHCF can estimate that this figure would be very low. Columns 2 and 3 in Question 57a show that 94% of ABD beneficiaries were passively renewed in FY 2025 and FY 2026 to date. Column 4 in Question 57a shows that only 6% received a non-passive renewal form (an average of 180 beneficiaries per month). The number of beneficiaries that lost coverage due to an increase in income would be a subset of column 4.

58. Of the Qualified Medicare Beneficiary (“QMB”) population, how many were sent the Non-MAGI Renewal Form, both as a raw number and percentage of the overall in FY 2025 and in FY 2026, to date?

- a. How many QMB enrollees were sent the Conversion Renewal Form as a raw number and percentage of the overall QMB population in FY 2025 and in FY 2026, to date?**
 - i. For the QMB population that was sent the Conversion Renewal Form, how many returned that form before the termination of their Medicaid coverage? And how many returned the form after the termination of their coverage but within the 90-day grace period in FY 2025 and in FY 2026, to date?**
 - ii. For the QMB population that was sent the non-MAGI Renewal Form, how many returned that form before the termination of their Medicaid coverage? And how many returned the form after the termination of their coverage but within the 90-day grace period in FY 2025 and in FY 2026 to date?**

Response:

For Qualified Medicare Beneficiary (QMB) only individuals (i.e., those with Medicaid coverage limited to payment of Medicare premiums and cost sharing) are required to submit the non-MAGI renewal form type, see column 6 of the table below. The table reflects Medicaid enrollees required to renew in FY 2025 and FY 2026 YTD.

- a. For Qualified Medicare Beneficiary (QMB) only individuals (i.e., those with Medicaid coverage limited to payment of Medicare premiums and cost sharing) are required to submit the conversion renewal form type, see column 5 of the table below. The table reflects Medicaid enrollees required to renew in FY 2025 and FY 2026 YTD.

Medicaid QMB Only Beneficiaries Passively Renewed and Receiving Non-Passive Renewal Form by Form Type, FY 2025 and FY 2026 to Date

1	2	3	4	5	6
Recertification Date	QMB-only beneficiaries due for renewal	QMB-only beneficiaries passively renewed	QMB-only beneficiaries receiving non-passive renewal form	QMB-only beneficiaries required to complete the conversion form	QMB-only beneficiaries required to complete the non-MAGI form
Number of beneficiaries					
2024-10-31	1,048	512	536	72	464
2024-11-30	1,750	1,279	471	93	378
2024-12-31	361	245	116	20	96
2025-01-31	309	228	81	6	75
2025-02-28	902	687	215	50	165

1	2	3	4	5	6
Recertification Date	QMB-only beneficiaries due for renewal	QMB-only beneficiaries passively renewed	QMB-only beneficiaries receiving non-passive renewal form	QMB-only beneficiaries required to complete the conversion form	QMB-only beneficiaries required to complete the non-MAGI form
2025-03-31	887	684	203	44	159
2025-04-30	929	683	246	41	205
2025-05-31	950	673	277	42	235
2025-06-30	728	366	362	10	352
2025-07-31	784	376	408	20	388
2025-08-31	1,170	823	347	33	314
2025-09-30	1,167	827	340	22	318
2025-10-31	1,263	972	291	64	227
2025-11-30	1,823	944	879	15	864
2025-12-31	579	282	297	11	286
Percent of total receiving non-passive renewal form					
2024-10-31	100%	49%	51%	7%	44%
2024-11-30	100%	73%	27%	5%	22%
2024-12-31	100%	68%	32%	6%	27%
2025-01-31	100%	74%	26%	2%	24%
2025-02-28	100%	76%	24%	6%	18%
2025-03-31	100%	77%	23%	5%	18%
2025-04-30	100%	74%	26%	4%	22%
2025-05-31	100%	71%	29%	4%	25%
2025-06-30	100%	50%	50%	1%	48%
2025-07-31	100%	48%	52%	3%	49%
2025-08-31	100%	70%	30%	3%	27%
2025-09-30	100%	71%	29%	2%	27%
2025-10-31	100%	77%	23%	5%	18%
2025-11-30	100%	52%	48%	1%	47%
2025-12-31	100%	49%	51%	2%	49%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: See notes applicable to all tables at the end of this document.

- i. See column 3 below for the number of Medicaid QMB only beneficiaries who returned a conversion renewal form before the termination of their Medicaid coverage. Most of these individuals would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was included to highlight additional individuals who retain coverage despite not returning a form prior to their certification date, reflecting non-MAGI beneficiaries who responded during their one-month extension. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal. See column 6 for the number who returned the form after the termination of their coverage but within the 90-day grace period. This group is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to

their renewal.

Column 7 reflects beneficiaries who returned a renewal but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

Medicaid QMB Only Beneficiaries Receiving Conversion Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	QMB-only beneficiaries required to complete the conversion renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but never terminated	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 (subset of 4)	
Number of beneficiaries						
2024-10-31*	72	49	10	1	0	12
2024-11-30*	93	57	17	8	7	11
2024-12-31*	20	11	5	1	0	3
2025-01-31*	6	1	3	0	0	2
2025-02-28*	50	23	14	7	3	6
2025-03-31*	44	26	8	3	1	7
2025-04-30	41	23	18		6	0
2025-05-31	42	23	19		2	0
2025-06-30	10	5	5		1	0
2025-07-31	20	9	11		4	0
2025-08-31	33	12	20		2	1
2025-09-30	22	13	9		4	0
2025-10-31	64	23	41		5	0
2025-11-30	15	12	3		1	0
2025-12-31	11	8	3		0	0
Percent of total receiving non-passive renewal form						
2024-10-31*	100%	68%	14%	1%	0%	17%
2024-11-30*	100%	61%	18%	9%	8%	12%
2024-12-31*	100%	55%	25%	5%	0%	15%
2025-01-31*	100%	17%	50%	0%	0%	33%
2025-02-28*	100%	46%	28%	14%	6%	12%
2025-03-31*	100%	59%	18%	7%	2%	16%
2025-04-30	100%	56%	44%		15%	0%
2025-05-31	100%	55%	45%		5%	0%
2025-06-30	100%	50%	50%		10%	0%
2025-07-31	100%	45%	55%		20%	0%

1	2	3	4	5	6	7
Recertification Date	QMB-only beneficiaries required to complete the conversion renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but never terminated	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 (subset of 4)	
2025-08-31	100%	36%	61%		6%	3%
2025-09-30	100%	59%	41%		18%	0%
2025-10-31	100%	36%	64%		8%	0%
2025-11-30	100%	80%	20%		7%	0%
2025-12-31	100%	73%	27%		0%	0%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: See notes applicable to all tables at the end of this document.

- ii. See column 3 below for the number of Medicaid QMB only beneficiaries who returned a non-MAGI renewal form before the termination of their Medicaid coverage. Most of these individuals would retain coverage, but as indicated in table notes this group also includes a small number determined ineligible. Column 5 was included to highlight additional individuals who retain coverage despite not returning a form prior to their certification date, reflecting non-MAGI beneficiaries who responded during their one-month extension. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

See column 6 for the number who returned the form after the termination of their coverage but within the 90-day grace period. This group is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period. Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

Column 7 reflects beneficiaries who returned a renewal, but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available.

Medicaid QMB Only Beneficiaries Receiving Non-MAGI Renewal Form and Selected Outcomes, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7
Recertification Date	QMB-only beneficiaries required to complete the non- MAGI renewal form (3+4+5+7)	Date of renewal received is known				Renewal received with an unknown date
		Returned a renewal form prior to the end of their certification period	Terminated for failure to manually renew prior to the end of their certification period	Did not return renewal form prior to end of certification period but never terminated	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 (subset of 4)	
Number of beneficiaries						
2024-10-31*	464	328	92	9	26	35
2024-11-30*	378	241	82	19	18	36
2024-12-31*	96	66	20	2	5	8
2025-01-31*	75	43	21	5	7	6
2025-02-28*	165	101	48	8	12	8
2025-03-31*	159	95	37	9	9	18
2025-04-30	205	141	64		18	0
2025-05-31	235	152	83		19	0
2025-06-30	352	229	123		41	0
2025-07-31	388	255	133		50	0
2025-08-31	314	225	89		39	0
2025-09-30	318	234	84		27	0
2025-10-31	227	156	71		29	0
2025-11-30	864	529	335		101	0
2025-12-31	286	168	118		4	0
Percent of total receiving non-passive renewal form						
2024-10-31*	100%	71%	20%	2%	6%	8%
2024-11-30*	100%	64%	22%	5%	5%	10%
2024-12-31*	100%	69%	21%	2%	5%	8%
2025-01-31*	100%	57%	28%	7%	9%	8%
2025-02-28*	100%	61%	29%	5%	7%	5%
2025-03-31*	100%	60%	23%	6%	6%	11%
2025-04-30	100%	69%	31%		9%	0%
2025-05-31	100%	65%	35%		8%	0%
2025-06-30	100%	65%	35%		12%	0%
2025-07-31	100%	66%	34%		13%	0%
2025-08-31	100%	72%	28%		12%	0%
2025-09-30	100%	74%	26%		8%	0%
2025-10-31	100%	69%	31%		13%	0%
2025-11-30	100%	61%	39%		12%	0%
2025-12-31	100%	59%	41%		1%	0%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: See notes applicable to all tables at the end of this document.

Notes applicable to tables that appear under responses to items a and b:

Starting with the April 2025 cohort, non-MAGI beneficiaries stopped receiving a one-month extension to respond to their renewal.

* Due to a system process implemented to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated), renewal outcomes for these months are updated prior to the beneficiary's next renewal initiation. In this process, dates on the renewal may no longer be readily available. As a result, this leads to a large number of renewals with unknown dates and we are unable to determine the columns to which they belong in the table.

- Column 3 includes a small number of beneficiaries who responded before the grace period but were determined ineligible. In addition, column 3 includes only beneficiaries who responded before the certification date; non-MAGI beneficiaries who responded during their one-month extension are not included (through the 3/2025 cohort).
- Column 4 reflects non-MAGI beneficiaries terminated after the one-month extension (through the 3/2025 cohort).
- Column 5 reflects non-MAGI beneficiaries who responded during their one-month extension (through the 3/2025 cohort) and becomes zero starting in April 2025 when the one-month extension ended.
- Column 6 is a subset of column 4 and reflects non-MAGI beneficiaries terminated after the one-month extension who returned a renewal form during their 90-day grace period (through the 3/2025 cohort). These individuals regain coverage in DHCF's Medicaid Management Information System (MMIS) until their renewal is processed; most are ultimately determined eligible but a small number are determined ineligible and disenrolled. The grace period for the October 2025 and later cohorts is incomplete and the number of beneficiaries to regain coverage from these groups is expected to increase. There are likely some individuals who re-enrolled but whose re-enrollment is not shown as a renewal in DCAS reports used to conduct this analysis.
- Column 7 reflects beneficiaries who returned a renewal but the date is currently unknown. A system process to ensure that existing renewals are fully recognized in DCAS (which allows future renewals to be initiated) affects recertification dates beginning with October 2023 and led to an increase in renewals in these months with dates that are no longer readily available

59. Of the people who had their Medical Assistance terminated in FY 2025 and FY 2026, how many of those people (both as a raw number and percentage of total) had their coverage terminated because DHS determined they no longer met the requirements of their existing Medical Assistance eligibility category in FY 2025 and in FY 2026, to date?

a. Of those Medicaid participants who lost their coverage because they no longer qualified under their existing eligibility group, how many / what percentage of those participants were enrolled, in FY 2025 and in FY 2026 to date, in:

- i. **ABD Medicaid**
- ii. **Long-Term Care Medicaid**
- iii. **Children on Medicaid**
- iv. **Parents / Caretaker Relatives**
- v. **Childless Adult Medicaid**
- vi. **Pregnant Individuals**
- vii. **Qualified Medicare Beneficiary (QMB)**

Response:

See column 2 of table below for the total number of beneficiaries terminated due to a determination of ineligibility. The table reflects Medicaid enrollees required to renew in FY 2025 and FY 2026 YTD.

a. See columns 3 through 10 of the table below for the number of beneficiaries determined ineligible by eligibility group.

Medicaid Beneficiaries Determined Ineligible by Eligibility Group, FY 2025 and FY 2026 to Date

1	2	3	4	5	6	7	8	9	10
Recertification Date	Determined ineligible before or after their certification period	ABD	Long-term care	Children	Parent / caretaker relatives	Childless adults	Pregnant individuals	QMB-only	Other adults
Number of beneficiaries									
2024-10-31	589	23	6	253	176	97	2	29	3
2024-11-30	489	25	0	220	137	85	0	21	1
2024-12-31	461	12	3	182	121	132	1	7	3
2025-01-31	362	4	6	173	101	72	0	5	1
2025-02-28	190	5	5	43	101	26	1	9	0
2025-03-31	202	3	2	48	111	36	0	2	0
2025-04-30	508	0	0	101	221	185	0	1	0
2025-05-31	288	2	0	59	155	69	1	2	0
2025-06-30	363	0	1	96	147	116	3	0	0
2025-07-31	365	1	1	89	175	97	1	0	1

1	2	3	4	5	6	7	8	9	10
Recertification Date	Determined ineligible before or after their certification period	ABD	Long-term care	Children	Parent / caretaker relatives	Childless adults	Pregnant individuals	QMB-only	Other adults
2025-08-31	217	1	0	60	106	49	0	1	0
2025-09-30	81	1	2	21	43	13	0	1	0
2025-10-31	112	0	3	38	51	17	0	3	0
2025-11-30	72	0	1	23	30	16	0	1	1
2025-12-31	104	0	0	19	45	38	0	2	0
Percent of total determined ineligible									
2024-10-31	100%	4%	1%	43%	30%	16%	0%	5%	1%
2024-11-30	100%	5%	0%	45%	28%	17%	0%	4%	0%
2024-12-31	100%	3%	1%	39%	26%	29%	0%	2%	1%
2025-01-31	100%	1%	2%	48%	28%	20%	0%	1%	0%
2025-02-28	100%	3%	3%	23%	53%	14%	1%	5%	0%
2025-03-31	100%	1%	1%	24%	55%	18%	0%	1%	0%
2025-04-30	100%	0%	0%	20%	44%	36%	0%	0%	0%
2025-05-31	100%	1%	0%	20%	54%	24%	0%	1%	0%
2025-06-30	100%	0%	0%	26%	40%	32%	1%	0%	0%
2025-07-31	100%	0%	0%	24%	48%	27%	0%	0%	0%
2025-08-31	100%	0%	0%	28%	49%	23%	0%	0%	0%
2025-09-30	100%	1%	2%	26%	53%	16%	0%	1%	0%
2025-10-31	100%	0%	3%	34%	46%	15%	0%	3%	0%
2025-11-30	100%	0%	1%	32%	42%	22%	0%	1%	1%
2025-12-31	100%	0%	0%	18%	43%	37%	0%	2%	0%

Source: DHCF eligibility system data extracted January 5, 2026.

Notes: ABD is Aged, Blind, or Disabled; QMB is Qualified Medicare Beneficiary; “Other adults” reflects adults excluded from other groups, such as incarcerated.

60. Regarding new applications for Medicaid in FY 2025 and in FY 2026, to date, please provide:

- a. The number of applications that were submitted through District Direct (broken down by District Direct mobile app and District Direct Website if available) online;**
- b. The number of applications submitted in person at ESA Service Centers;**
- c. For applications not based on disability, please provide:**
 - i. The number of these applications that were processed within 45 days of submission;**
- d. For applications based on disability, please provide:**
 - i. The number of these applications that were processed within 90 days of submission; and**
 - ii. For those applications that were not processed within 90 days, the reasons for any delays and what DHCF is doing to prevent such delays in the future.**

Response:

- a. The number of applications that were submitted through District Direct (broken down by District Direct mobile app and District Direct Website if available) online**

The table below presents the total number of applications received each month of FY25 and FY26 YTD, along with the numbers that were submitted online.

Month	Total applications	Online applications
Oct-24	1,500	1,129
Nov-24	1,359	965
Dec-24	1,528	1,117
Jan-25	1,737	1,243
Feb-25	1,416	991
Mar-25	1,718	1,175
Apr-25	1,462	1,027
May-25	1,364	945
Jun-25	1,172	813
Jul-25	1,359	986
Aug-25	1,213	833
Sep-25	1,263	839
Oct-25	1,173	824
Nov-25	929	645
Dec-25	1,009	706

Source: DHCF eligibility system data compiled as of January 5, 2026.

Notes: Online reflects the District Direct website and mobile app.

- b. The number of applications submitted in person at ESA Service Centers;**

The table below presents the total number of applications received each month of FY25 and FY26 YTD, along with the number that were submitted in-person.

Month	Total applications	Applications submitted in person
Oct-24	1,500	346
Nov-24	1,359	343
Dec-24	1,528	379
Jan-25	1,737	449
Feb-25	1,416	386
Mar-25	1,718	489
Apr-25	1,462	394
May-25	1,364	388
Jun-25	1,172	328
Jul-25	1,359	345
Aug-25	1,213	353
Sep-25	1,263	397
Oct-25	1,173	315
Nov-25	929	263
Dec-25	1,009	281

Source: DHCF eligibility system data compiled as of January 5, 2026.

c. For applications not based on disability, please provide:

- i. The number of these applications that were processed within 45 days of submission.**

See table below under item d. It provides the percentage of MAGI applications (which reflect those that are not based on disability) processed within 45 days.

d. For applications based on disability, please provide:

- i. The number of these applications that were processed within 90 days of submission.**

See table below. It provides the percentage of non-MAGI applications (which reflect those based on disability, as well as those for individuals who are age 65 and older or in need of long-term care) processed within 90 days.

- ii. For those applications that were not processed within 90 days, the reasons for any delays and what DHCF is doing to prevent such delays in the future.**

See response to Question 61.

Percent of Applications Processed Timely, FY 25 - FY 26 YTD

Month	Percent of MAGI Applications Processed Within 45 Days	Percent of Non-MAGI Applications Processed Within 90 Days
Oct-24	86%	93%
Nov-24	88%	94%
Dec-24	88%	98%
Jan-25	88%	88%
Feb-25	92%	99%
Mar-25	92%	99%
Apr-25	88%	97%
May-25	90%	86%
Jun-25	88%	95%
Jul-25	86%	96%
Aug-25	80%	92%
Sep-25	75%	91%
Oct-25	72%	95%
Nov-25	70%	100%
Dec-25	71%	93%

Source: DHCF eligibility system data compiled as of January 5, 2026.

Notes: This table reflects processing time data submitted in the Performance Indicator data set to the Centers for Medicare & Medicaid Services (CMS). It follows CMS specifications and reflects all applications that have a determination in each month and defines "timely" as a processing time of 45 days or less for MAGI applications and 90 days or less for non-MAGI applications.

61. Please describe DHCF's efforts to reduce any backlog in processing applications including:

- a. The metrics used to indicate backlog(s) have been reduced, and by how much; and**
- b. Steps DHCF has taken in FY 2025 or will take over the remainder of FY 2026 to investigate whether such backlogs exist, both for applications submitted online and for applications submitted at ESA Service Centers.**

Response:

A summary of other key steps DHCF and DHS have taken to decrease backlogs and improve processing, is summarized below:

Ex Parte Process for Non-Magi Programs.

Ex Parte or Passive renewals are federally-required. We first attempt to renew the case using reliable information/electronic data sources without contacting the beneficiary. All MAGI programs are reviewed for the ex parte/passive process, as well as the Aged, Blind, and Disabled (ABD) groups and Qualified Medicare Beneficiaries (QMB).

Streamlined Renewal Process for Long Term Care Programs.

CMS approved a progressive route for DHCF to utilize that begins the ex parte/passive renewal process for our long-term care programs. This process is broken up in three phases. The first phase started in November 2024, and we began passively renewing all Long-Term Care (LTC) waiver programs. In phase 2 and 3, we will begin adding interface information automatically to DCAS to verify the level of care and improve the institutionalized calculation cost of care process to improve efficiency. By the end of phase 3, there will be an attempt to use electronic data sources to passively renew LTC programs.

Workforce Training, Augmentation, and Deployment.

Caseworkers are cross-trained to ensure they can process all social services programs (SNAP, TANF, Medicaid, Alliance). DHCF has regular scheduled meetings with DHS's policy and training team to ensure alignment on policies and Medicaid changes. DHCF funded a contract from April 2023 through April 2025 that provided additional staff members to log applications and renewals that were handwritten or faxed into the system; staff members from that contract entered in 27,422 cases in FY23, 24,099 cases in FY24, and 10,056 in FY25.

Part (a):

The number of medical applications pending generally exceeds 1,000 in any given month. This figure is based on registered applications that either require an applicant response to a request for information notice or processing by a case worker in order to receive an eligibility determination; it excludes applications not yet registered in DCAS. DHCF monitors the timeliness of application processing in part through a review of the percentage of Medicaid MAGI applications taking more than 45 days to process and the percentage of non-MAGI taking more than 90 days. In FY 2025 and FY 2026 Q1, the MAGI percentage ranged from 8% to 30% and the non-MAGI percentage ranged from 0% to 14%.

Part (b):

DHCF and DHS coordinate to ensure timely processing of all medical assistance applications and renewals.

Large numbers of pending cases, when not processed completely, have the ability to disrupt the polling process that happens as a component of renewal. Polling is part of the Medicaid renewal initiation process where DHCF checks electronically available information to determine the continued eligibility of enrolled beneficiaries. To mitigate this, DHCF has implemented a process that resolves all pending cases, prior to the initiation of polling. This process, along with other efficiencies, has lowered the number of cumulative outstanding renewal cases.

62. At any point in FY 2025 or in FY 2026, to date, has DHCF encountered "stuck" or "malformed" Medicaid applications?

- a. **If so, how many applications have been affected in FY 2025 and in FY 2026, to date?**
- b. **What is the average number of days that it has taken households affected by this "stuck" or "malformed" error to receive a Medicaid eligibility determination?**

Response:

There are currently no issues with stuck or malformed applications. Prior instances stemmed from application data feeds between DC Health Link and DCAS. The issue was resolved after the deployment of Release 3 in FY2022 when new data structures were put in place.

63. How many adults enrolled in Emergency Medicaid in FY 2025 and FY 2026, to date?

- a. Please provide the average length of coverage for beneficiaries and cost per enrollee.**

Response:

The number of adults age 21 and older with emergency Medicaid claims for dates of service in FY 2025 is 3,849; it is 670 in FY 2026 to date.

- a. The District provides emergency Medicaid coverage for most individuals by claiming federal match for certain emergency services paid by DHCF for beneficiaries who are enrolled in Alliance coverage. Only a small number of individuals are currently enrolled in Medicaid (rather than Alliance) under an emergency Medicaid program code.

Among the 3,849 adults with emergency Medicaid claims in FY 2025, the average number of months with emergency Medicaid service use was 1.3 and the average payment per user for these services was \$11,377.

64. How many beneficiaries enrolled in the Program for All-Inclusive Care for the Elderly (PACE) program in FY 2025 and FY 2026, to date?

- a. What are the District's plans for expanding and/or improving the PACE program in FY 2026 and FY 2027?**

Response:

As of 12/31/25, the PACE program has a total enrollment of 48 participants.

- a. The District is focused on improving the current performance of the PACE provider organization and DHCF is not currently planning any expansion to the PACE program. On 10/28/24, the PACE program was placed under a Corrective Action Plan (CAP) to address deficiencies identified by the District and the Centers for Medicare & Medicaid Services (CMS), in accordance with federal regulations (42 C.F.R. Part 460) and Contract CW94623. The program remains under this CAP.

DHCF continues to work with the PACE provider to address the deficiencies outlined in the CAP. Efforts include implementing corrective actions, proposed modification to the current contract requirements to strengthen oversight deliverables, and providing technical, clinical, and operational support to the program.

65. Please provide the total number of people enrolled in the elderly and persons with disabilities (EPD) waiver in FY 2025 and FY 2026, to date.

Response:

For FY25, and FY26 (As of 12/31/25), the EPD Waiver Program enrollment was 6530.

66. How many Dual Choice enrollees were also enrolled in the EPD waiver in FY 2025 and FY 2026, to date?

Response:

For FY25, there were 3058 unique Dual Choice enrollees in the EPD Waiver Program. Currently for FY26, (10/1/25 through 12/31/25), there are 2833 Dual Choice enrollees in the EPD Waiver Program.

67. Please confirm if DHCF assesses medical eligibility for the EPD waiver through the InterRAI assessment administered by Telligen.

- a. **If not, what assessment tool does DHCF use to determine medical eligibility?**
- b. **Are Dual Choice enrollees who receive coverage through the EPD waiver assessed by Telligen?**

Response:

DHCF uses the InterRAI Home Care (HC) assessment as the standardized, comprehensive tool to evaluate the needs, strengths, and preferences of individuals receiving care at home. The tool captures detailed information on physical health, cognitive status, daily functioning, mental well-being, and social support, enabling care providers to develop personalized care plans and allocate resources effectively. Telligen conducts all LTSS assessments for DHCF's Long Term Care programs, including Fee for Service, and Dual eligible enrollees in both PACE and DSNP (Dual Choice) Program. Telligen does not conduct non-LTSS initial assessments for beneficiaries enrolled in other Medicaid programs such as DC Healthy Families Program Managed Care Plans, which include AmeriHealth, MedStar, Amerigroup, and HSCSN. These non-LTSS assessments remain the responsibility of MCPs as outlined in their respective contracts.

67. Please confirm if DHCF assesses medical eligibility for the EPD waiver through the InterRAI assessment administered by Telligen.

- a. **If not, what assessment tool does DHCF use to determine medical eligibility?**
- b. **Are Dual Choice enrollees who receive coverage through the EPD waiver assessed by Telligen?**

Response:

DHCF uses the InterRAI Home Care (HC) assessment as the standardized, comprehensive tool to evaluate the needs, strengths, and preferences of individuals receiving care at home. The tool captures detailed information on physical health, cognitive status, daily functioning, mental well-being, and social support, enabling care providers to develop personalized care plans and allocate resources effectively. Telligen conducts all LTSS assessments for DHCF's Long Term Care programs, including Fee for Service, and Dual eligible enrollees in both PACE and DSNP (Dual Choice) Program. Telligen does not conduct non-LTSS initial assessments for beneficiaries enrolled in other Medicaid programs such as DC Healthy Families Program Managed Care Plans, which include AmeriHealth, MedStar, Amerigroup, and HSCSN. These non-LTSS assessments remain the responsibility of MCPs as outlined in their respective contracts.

68. Please confirm whether case managers for Dual Choice enrollees in the EPD waiver are provided directly by the Dual Choice Plan or by the private case management agencies that contract directly with DHCF.

- a. **If by the Dual Choice plan, how many case managers for the EPD waiver program did the Dual Choice plan employ in FY 2025 and FY 2026, to date?**
 - i. **If not, how many case managers are assigned to EPD waiver beneficiaries who are enrolled in the Dual Choice Plan, and who employs them?**
- b. **What was the ratio of case managers to EPD waiver beneficiaries for Dual Choice enrollees in FY 2025 and FY 2026, to date?**

Response:

In the Dual Choice Plan, a total of 55 case managers are employed to support the EPD Waiver program as of 12/31/25. United Health Care's hiring activity for FY25 and FY26 to date shows that 25 case managers were onboarded between 10/1/24 and 9/30/25, with an additional 10 hired between 10/1/25 and 12/31/25.

In addition to directly employed staff, several Contracted Management Agencies (CMAs) also provide case management (CM) support for EPD waiver beneficiaries enrolled in the Dual Choice Plan. As of 12/31/25, these contacted CMAs collectively supplied 10 case managers across six agencies. Only one CMA case manager was hired during the period of 10/1/24 through 9/30/25, and no CMA case managers were hired between 10/1/25 and 12/31/25.

Per 29 DCMR Chapter 42, a case manager's caseload may not exceed forty-five individuals at any time, inclusive of both Medicaid and non-Medicaid beneficiaries served across all case management agencies. In addition, each case manager's caseload must be proportionate to the number of hours the case manager works per week, ensuring that workload aligns with available staffing capacity. This requirement is applicable to both Fee-For-Service and Dual Choice case managers.

Dual Choice (DSNP) Case Management Staffing Summary Table

Total # CMs as of 12/31/25	55
Timeline	EPD CMs Hired
10/1/2024 – 9/1/2025	25
10/1/2025 – 12/31/2025	10
Current # of contracted CMA CMs as of 12/31/25	• Autumn Leaf: 2 CMs • Family Healthcare Solutions: 2 CMs • KCC: 1 CM • Absolute Healthcare Resources: 2 CMs • Ultimate: 1 CM • Progressive: 2 CMs

Timeline	EPD CMA CMs Hired
10/1/2024 – 9/1/2025	• Absolute Healthcare Resources: 1 CM
10/1/2025 – 12/31/2025	• No CMA CMs hired during this timeframe

69. In FY 2025 and FY 2026, to date, how many Home Health Agencies are approved by DHCF as providers of Personal Care Aide (“PCA”) hours for individuals enrolled in the Medicaid State Plan and the EPD waiver program?

- a. Though DHCF does not require home health agencies to report all employed PCAs, please share DHCF’s most accurate estimate for FY 2025 and FY 2026, to date, for how many Personal Care Aides are employed by each Home Health Agency.**

Response:

8,377 unduplicated PCAs were employed by Home Health Agencies (HHAs) in 2025. The aggregate number of PCAs reported by individual providers is higher than the overall total because some PCAs work for more than one provider. DHCF does not have data for FY2026 so we estimate the number of PCAs working in FY2026 will be the same as FY2025.

See Q69-Attachment 1.

Q69-Attachment 1

Provider	Number of PCAs
ABA Home Health Care	471
Alliance Home Health Care and Equipment Services	141
Berhan Home Health Care Agency, Inc.	263
Capital Care, Inc.	643
Capitol View	122
DC Home Health Holding DBA VMT	365
Direct Care Home Health Services LLC	182
Health Management, Inc.	379
Human Touch Home Health Care Agency, Inc.	229
Ideal Nursing Services, Inc	322
Immaculate Health Care Services	333
Integrated Community Services, Inc.	933
KBC Nursing Agency Home Health	474
Lifeline Inc	718
Linac Services, Inc.	145
Maxim Healthcare Services, Inc.	50
MBI Health Services	433
MJ General LLC	521
Open Systems Health Care	417
Palisades Healthcare Partners Inc	146
Premier Health Services	316
Premium Select Home Care, Inc	362
T&N Reliable Nursing Care, LLC	634
Universal Home Healthcare	471
Grand Total	9,070

Note: The number of PCAs working by provider is higher than the total number of PCAs working in HHAs because some PCAs work for more than one provider.

71. Please provide 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, broken down by:

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

Response:

Based on 9,517 Medicaid-enrolled beneficiaries' and Medicaid applicants' LTSS assessments completed during FY25:

- a. 601 beneficiaries (6%) were assessed for 16 to 17 hours of PCA services per day, including 347 beneficiaries (4%) who were specifically recommended 16 hours per day.
- b. 90 beneficiaries (1%) were assessed for 18 or 19 hours of PCA services per day.
- c. Less than 1% (0.042%), representing 4 assessments, were assessed for 20 to 23 hours of PCA services per day.
- d. 365 beneficiaries (3.8%) were assessed as needing 24 hours of Personal Care Aide (PCA) services per day, seven days a week.

72. How many EPD waiver participants have been terminated from the EPD waiver program each month because their recertification was not submitted on a timely basis in FY 2025 and in FY 2026, to date?

- a. **Of those EPD waiver participants who have had their EPD waiver coverage terminated because their recertification was not submitted timely, how many recertifications were completed during the 90-day grace period in FY 2025 and in FY 2026, to date?**
- b. **How many EPD waiver participants have lost their EPD waiver coverage because their recertification was not timely submitted prior to the date of termination and was not submitted during the 90-day grace period in FY 2025 and in FY 2026, to date?**

Response:

During FY 2025, DHCF implemented a passive renewal process for EPD waiver participants that assumed a beneficiary's level of care remained the same and resulted in almost 100% of beneficiaries being renewed passively.

On average, 478 beneficiaries were included per recertification period. During FY 2026, DHCF made additional changes to the EPD renewal process to include level of care data, which resulted in the passive renewal rate declining to about 90% in the first quarter of the fiscal year, causing 21 beneficiaries to remain terminated after the grace period as of 1/6/25 (this is not the final termination count as it is currently the grace period for these cohorts). DHCF will continue to monitor the impact of renewal changes for EPD beneficiaries.

73. Please provide the criteria used by DHCF and/or Managed Care Organizations, or the District Dual Choice D-SNP plan, to make medical necessity determinations regarding the number of PDN hours for FY 2025 and FY 2026, if different than previous years.

- a. **Please confirm if DHCF uses criteria created by InterQual to evaluate medical necessity determination for PDN hours.**

Response:

The medical necessity criteria remain unchanged. DHCF uses InterQual criteria, as does Amerihealth, HSCSN, Medstar, and United Health. Amerigroup uses the Milliman Care Guidelines.

For long-term care, Private Duty Nursing (PDN) services are governed by DCMR Section 947.5, which defines these services as medically necessary for technology-dependent beneficiaries who rely on life-sustaining technology, such as ventilators, to maintain essential bodily functions and who require continuous nursing supervision to ensure ongoing visual assessment and equipment safety. Initial reviews are conducted by licensed clinical reviewers from quality improvement organizations, using InterQual criteria, ASAM guidelines, DHCF regulations, and organizational protocols, along with supporting documentation including the 719A form, the plan of care, medical necessity letters, and clinical records.

74. Of the Medicaid recipients who received PDN hours in FY 2025 and FY 2026, to date, how many (raw number and percentage) received any Personal Care Aide (PCA) service hours?

- a. Of the Medicaid recipients who receive both PDN and PCA hours, how many (raw number and percentage) received their PCA services through the EPD waiver?**

Response:

During the CY25 (10/1/24–9/30/25) and CY26 (10/1/25–12/31/25), there were 91 recipients with paid claims for Private Duty Nursing (PDN) services. Of these, 69 recipients (approximately 76%) had EPD Waiver enrollment and also had overlapping Personal Care Aide (PCA) services based on provider claims. The distribution of overlapping PCA services was highly concentrated, with the top three billing providers accounting for 36 recipients (52.2%).

75. How many Medicaid recipients (both State Plan and EPD waiver enrollees) received 24 hours of PDN care at any point during FY 2025 and FY 2026, to date?

- a. **Of the recipients who received 24 hours of PDN care during FY 2025 and FY 2026 to date, how many (both as a raw number and percentage) experienced a reduction of those services at some point during the last year?**

Response:

During FY25 and FY26, 44 recipients received the maximum level of Private Duty Nursing (PDN) care, which is 24 hours per day. Of these, three recipients experienced a reduction in their PDN hours, representing 6.82% of those receiving full-time care. The reductions varied significantly: one recipient's hours were reduced to 2,880 units, which is a 50% decrease from the maximum of 5,760 units; another recipient's hours were reduced to 1,824 units, a 68.33% decrease; and the third recipient's hours were reduced to 4,032 units, a 30% decrease. Among the three recipients who experienced a reduction, one appealed the recommended change, accounting for 33% of those affected. Overall, the percentage of recipients who received any reduction in care during the reporting period was 6.82%.

See summary table:

	Description	Total Count	Percentages
	Recipients who received 24 hours of PDN Care	44	
	Recipients who received a reduction in PDN hours from 24 hours	3	6.82%
	Of the 3 Recipients who received a reduction in PDN hours from 24 hours	Amount Reduced to (from the maximum 5760 units:	
	Recipient 1	2880 units	50%
	Recipient 2	1824 units	68.33%
	Recipient 3	4032 units	30%
	Recipients who appealed the recommended reduction in PDN service	1	33%

Percentage of recipients who received reduction in care.

	6.82%

76. Of the Medicaid recipients who both: 1) received 24 hours of PDN hours and 2) experienced a reduction of those hours during FY 2025 and FY 2026, to date, how many of those individuals (both as a raw number and percentage) had their hours restored to 24 hours?

- a. **How many had some portion of their PDN hours restored, even if their hours were not restored to 24 hours?**
- b. **Of the people who had their PDN hours restored after a reduction, how many (raw number and percentage) had their hours restored after filing a reconsideration appeal?**
- c. **Of the people who had their PDN hours restored after a reduction, how many (raw number and percentage) had their hours restored after a fair hearing request at the Office of Administrative Hearings?**

Response:

Description	Total Count	Percentages
Medicaid Recipient Count FY2025 for PDN	440	
Medicaid Recipient Count FY2026 for PDN	99	
Recipients who received 24 hours of PDN Care	44	8%
Recipients who received a reduction in PDN hours from 24 hours	3	6.82%
Of the 3 Recipients who received a reduction in PDN hours from 24 hours	Amount Reduced to (from the maximum 5760 units:	
Recipient 1	2880 units	50%
Recipient 2	1824 units	68.33%
Recipient 3	4032 units	30%
Recipients who appealed the recommended reduction in PDN service	1	33%
Percentage of recipients who received reduction in care.		6.82%

77. Please provide us with the total number of EPD waiver participants who are receiving their PCA hours through participant-directed services (i.e. “Services My Way”) rather than through a Home Health Agency in FY 2025 and in FY 2026 to date. Please also provide the following information of the EPD waiver participants who receive their PCA hours through Service My Way:

- a. How many is DHCF reimbursing for the full number of approved PCA hours in FY 2025 and in FY 2026 to date?**
- b. How many are DHCF reimbursing for only some of the approved PCA hours in FY 2026 and in FY 2026 to date?**
- c. For cases where DHCF/an MCO is not reimbursing for the full number of approved PCA hours, how many EPD waiver participants are not being reimbursed for the following number of approved PCA hours in FY 2025 and in FY25 to date:**
 - i. Number of people for whom DHCF/an MCO is not reimbursing for 1 approved PCA hour.**
 - ii. Number of people for whom DHCF/an MCO is not reimbursing for 2 approved PCA hours.**
 - iii. Number of people for whom DHCF/an MCO is not reimbursing for 3 approved PCA hours.**
 - iv. Number of people for whom DHCF/an MCO is not reimbursing for 4 approved PCA hours.**
 - v. Number of people for whom DHCF/an MCO is not reimbursing for 5 or more approved PCA hours.**

Response:

The LTSS assessment methodology for determining minimum, midpoint, and maximum clinically recommended PCA service hours remain unchanged, with DHCF continuing to default to the maximum recommendation. Beneficiaries who choose to self-direct retain access to the default maximum PCA hours and maintain the right to request a fair hearing or reconsideration under both Fee-for-Service and Dual Choice models if dissatisfied with recommended or reimbursed services.

Reconciling authorized PCA hours with billed or reimbursed hours for specific dates remains challenging due to analytical constraints. Between October 1, 2024, and December 31, 2025, a total of 2,524 beneficiaries elected to self-direct and accessed Participant Directed Services (PDS) in lieu of PCA. Of these, 43 beneficiaries (1.7%) filed fair hearings disputing reductions in PCA/PDS services.

78. Please provide an update on the implementation of the Direct Support Professional Payment Rate Amendment Act of 2024, including:

- a. **Number of direct support professionals (DSP) who have been reimbursed in FY 2025 and FY 2026, to date;**
- b. **Number of DSPs who saw a rate increase in FY 2025;**
- c. **Timeline for implementing the Direct Care Professional Payment Rate Amendment Act of 2025; and**
- d. **Any anticipated challenges around implementing these subtitles, including strategies to address these challenges.**

Response:

- a. For FY 2025, providers reported in their DSP Wage Enhancement submissions that a total of 8,377 Personal Care Aides (PCAs) worked in Home Health Agencies and approximately 4,853 DSPs worked for IDD Waiver Service Providers.

DHCF has not yet received any reports for FY 2026. The report covering 10/1/25 – 12/31/25 (Q1 of FY26) is due in January.

- b. In FY25, approximately 8,210 PCAs working in Home Health Agencies and 4,644 DSPs working for DD Waiver Service Providers received wage increases.
- c. The American Rescue Plan Act (ARPA) funded supplemental payments for implementing the DSP Wage Enhancement ended on 12/31/25. Providers are expected to submit their final reports in January 2026, after which DHCF will reconcile the reports to address any underpayments or overpayments. Effective 1/1/26, through 9/30/26, funding for DSP Wage Enhancement has been incorporated into the regular provider rates. There is no funding available to continue wage enhancements beyond 9/30/26.
- d. During the implementation of the DSP Wage Enhancement, DHCF faced several challenges, including delays in the submission of required reports and instances where providers did not use the allocated funds as intended, either failing to meet the expected 17.6% average wage increase or exceeding it. Some providers also included non-DSP staff or contracted employees in their reports, complicating the review process. Additionally, audits revealed that certain providers lacked adequate documentation to support the rates or hours they reported. In response, DHCF has maintained ongoing engagement with providers and conducted targeted audits to strengthen oversight and ensure compliance.

80. How many births did DHCF pay for in FY 2025 and FY 2026, to date, for Medicaid and Alliance patients?

- a. What share of the total District resident births did Medicaid/Alliance-covered births represent in FY 2025?**
- b. Of the Medicaid enrollees who gave birth in FY 2025, how many will be shifted to a Healthy DC Plan when their 12-months postpartum coverage expires?**
- c. How many will be eligible for a QHP on the DC Health Exchange? What notifications and resources will these patients receive?**

Response:

The number of DHCF-funded births was 3,256 in FY 2025 and is 519 in FY 2026 to date.

- a. Based on provisional data available for January 1, 2025, through October 31, 2025 (the period currently available for both Districtwide and DHCF-funded births), the share of total District resident births funded by DHCF, including Medicaid/Alliance, was 43.4%.

This figure reflects 6,076 births Districtwide from CDC WONDER data for January through October 2025 and 2,640 DHCF-funded births for the same time frame. The CDC WONDER data is provisional as of November 30, 2025 (available at https://www.cdc.gov/nchs/data_access/vitalstatsonline.htm). DHCF data is as of January 2026 and will be higher when run at a future date due to lagged submission and payment of claims from providers.

- b. Based on a beneficiary's current income as of January 2026, there are 117 Medicaid enrollees who gave birth in FY 2025 who will potentially be shifted to a Healthy DC Plan when their 12-months postpartum coverage expires. Beneficiary circumstances (family size, income level, etc.) can change over time and would be reassessed at the end of the postpartum period to determine the appropriate coverage.
- c. Based on a beneficiary's current income as of January 2026, there are 51 Medicaid enrollees who gave birth in FY 2025 who will potentially be eligible for a QHP on the DC Health Exchange. Beneficiary circumstances (family size, income level, etc.) can change over time and would be reassessed at the end of the postpartum period to determine the appropriate coverage. Please refer to the Question 97 response for additional information on pregnancy and postpartum coverage.

81. How many women received prenatal care in their first trimester in FY 2024, FY 2025, and FY 2026 to-date? Please provide this data as a raw number and percentage, stratified by age and divided by MCO.

Response

Please see the following five tables for each Managed Care Plan and Final Totals, organized by Fiscal Year and Age Group.

AmeriHealth	AGE	Total received care in 1st Trimester	Total Deliveries	Percentage
FY2024	10-19	41	92	44.57%
	20-29	421	631	66.72%
	30-39	419	639	65.57%
	40-49	41	76	53.95%
	Total	922	1438	64.12%
FY2025	10-19	48	82	58.24%
	20-29	351	545	64.40%
	30-39	395	599	65.94%
	40-49	34	54	62.96%
	Total	828	1280	64.69%
FY2026	10-19	7	16	43.75%
	20-29	93	141	65.96%
	30-39	100	160	62.50%
	40-49	10	19	52.63%
	Total	210	336	62.50%

HSCSN	AGE	Total received care in 1st Trimester	Total Deliveries	Percentage
FY2024	10-19	10	15	66.7%
	20-29	29	43	67.4%
	Total	39	58	67.2%
FY2025	10-19	5	8	62.5%
	20-29	11	18	61.1%
	Total	16	26	61.5%
FY2026	10-19	0	1	0%
	20-29	3	3	100%
	Total	3	4	75%

MedStar Family Choice	AGE	Total received care in 1 st Trimester	Total Deliveries	Percentage
FY2024	10-19	26	36	72.22%
	20-29	185	239	77.41%
	30-39	172	251	68.53%
	40-49	12	16	75%
	Total	395	542	72.88%
FY2025	10-19	23	33	69.70%
	20-29	210	291	72.16%
	30-39	197	290	67.93%
	40-49	11	18	61.11%
	Total	441	632	69.78%
FY2026	10-19	7	13	53.85%
	20-29	52	65	80%
	30-39	43	51	84.31%
	40-49	1	1	100%
	Total	103	130	79.23%

Wellpoint	AGE	Total received care in 1 st Trimester	Total Deliveries	Percentage
FY2024	10-19	19	50	38%
	20-29	163	350	47%
	30-39	182	378	48%
	40-49	9	32	28%
	Total	373	811	46%
FY2025	10-19	27	56	48%
	20-29	191	372	51%
	30-39	182	334	54%
	40-49	17	33	52%
	Total	417	795	52%
FY2026	10-19	3	8	38%
	20-29	40	68	59%
	30-39	34	54	63%
	40-49	4	6	67%
	Total	81	136	60%

Total		Total 1 st Trimester	Total Deliveries	Percentage
FY2024		1729	2849	60.68%
FY2025		1702	2733	62.28%
FY2026		397	606	65.5%

82. Provide an update on the implementation of the State Plan Amendment to cover doula services, including:

- a. The number of doulas currently receiving reimbursement, broken down by FFS and each MCO.**
- b. The expected number of doulas to receive reimbursements in the remainder of FY 2026, broken down by FFS and each MCO.**
- c. Total reimbursements distributed to doulas in FY 2025 and FY 2026, to date, broken down by FFS and each MCO.**
- d. A narrative explanation on how DHCF continues to make doulas as well as DC residents aware of their eligibility for reimbursement; and**
- e. Each MCO's protocols for doula reimbursement including step-by-step instructions on how to bill the MCO including applicable codes and modifiers.**

Response

In 2022, DHCF established the Doula benefit for the Medicaid, Alliance, and Immigrant Children's Program(s), including a comprehensive service list, enrollment and certification standards, reimbursement rates, and billing protocols.

Utilization of doula services in both FFS and Managed Care has been lower than anticipated, with specific data provided below. The highest consumption of doulas services to-date has been for doulas participating in health centers and practice groups where revenue cycle management support exists and sources of referral are internal. DHCF is leveraging our Transforming Maternal Health (TMaH) grant, from the Centers for Medicare and Medicaid Innovation (CMMI), to enhance recruitment, provide technical assistance, for public education, and to increase the rate of referral. These efforts include collaboration with the MCPs, Doula Learning Action Collaborative, FQHCs, DC Health, and other District stakeholders.

- a. The number of doulas currently receiving reimbursement, broken down by FFS and each MCO.

(See Table)

- b. The expected number of doulas to receive reimbursements in the remainder of FY 2026, broken down by FFS and each MCO.

(See Table)

Plan	# Doulas	# Doula Grps	FY26 Anticipated
FFS	27	10	35
Amerihealth	4	0	7
HSCSN	1	0	5
MedStar Family Choice	4	1	7

Wellpoint	4	0	25% Increase each QTR

- c. Total reimbursements distributed to doulas in FY 2025 and FY 2026, to date, broken down by FFS and each MCO.

Plan	Total FY25	Total FY26
FFS	\$420.20	\$125.000
Amerihealth	\$11,609.89	\$420.20
HSCSN	\$0	\$0
MedStar Family Ch	\$1,005.05	\$0
Wellpoint	\$1,260.58	\$0

- d. A narrative explanation on how DHCF continues to make doulas as well as DC residents aware of their eligibility for reimbursement.

DHCF is leveraging the Transforming Maternal Health Model Grant (TMaH) to partner with the Doula Learning Action Collaborative and establish a State Doula Advisory Council. TMaH resources also support a Provider Incentive Program that enhances doulas' ability to deliver whole-person care. The provider incentive program offers financial incentives for quality improvement activities, strengthening doula revenue and reimbursement capacity. Additionally, the District is conducting beneficiary focus groups to gather insights on the doula benefit, which will inform strategies to increase awareness and utilization. DHCF's Managed Care Plan partners are also active collaborators for TMaH and our doula recruitment initiatives.

- e. Each MCO's protocols for doula reimbursement including step-by-step instructions on how to bill the MCO including applicable codes and modifiers.

See Attachment 1-4 to Q82

Q82 Attachment 1

Amerihealth Caritas DC – Protocols for Doula Reimbursement

Overview

Covered Service & Reimbursement

Perinatal Doula Support Visit

<i>CPT Code</i>	<i>Modifier Description</i>	<i>CY 2026 Rate</i>
99600-HD	Perinatal Doula Support Visit	\$107.89
59400-HD	Doula Support at Delivery Vaginal Delivery	\$762.98
59514-HD	Doula Support at Delivery C-Section	\$762.98
59612-HD	Doula Support at Delivery V-BAC	\$762.98
99199-HD	Postpartum Doula Support-15 min increment	\$13.48
99199-HD-U8	Doula Incentive Payment for OB Postpartum 7 to 84 days after labor and delivery	\$100.00

Please Note:

- Modifier HD is required on all doula claims.
- Claims submitted without HD will deny.

To bill AmeriHealth Caritas for doula services the doula must:

- Be a DC Medicaid–enrolled doula provider
- Meet DHCF certification requirements
- Maintain complete visit documentation

Diagnosis Codes

- Claims must include a valid perinatal diagnosis code.
- At least one diagnosis code is required.

Documentation Requirements

Doulas must document:

- Member name & Medicaid ID
- Date of service
- Type of encounter (prenatal, labor, postpartum)
- Summary of support provided
- Practitioner recommendation/referral
- Doula signature

Billing Instructions

Step 1 — Verify Eligibility

- Confirm the enrollee is enrolled in AmeriHealth Caritas Plan.
- Confirm the member is in the perinatal period (pregnancy through 6 weeks postpartum).

Step 2 — Provide Service

- Deliver prenatal, labor, or postpartum support consistent with DC Medicaid doula policy.

Step 3 — Document the Visit

- Ensure all required elements listed above are included.

Step 4 — Build the Claim

- Procedure Code
- Modifier:
- Units:
- Diagnosis code/codes
- All other pertinent data points to complete the claim

Step 5 — Submit the Claim

- Electronic Claims (Preferred)
- Electronic claims may be submitted via Availity or Optum/Change Healthcare

Submit via standard EDI

- AmeriHealth Caritas DC EDI payer number is 77002

Paper Claims (CMS-1500)
AmeriHealth Caritas District of Columbia Medicaid
Attention: Claims Processing Department
P.O. Box 7342 London, KY 40742

Step 6 — Follow Timely Filing Rules

- Submit within 365 days of service
- Corrected claims should be resubmitted within 365 days of service

Q82 Attachment 2

HSCSN- Protocols for Doula Reimbursement

Doula providers must follow the District's protocols for billing doula services by using the designated CPT codes and modifiers, as specified by the Department of Health Care Finance (DHCF). Below are the codes and modifiers as specified by DHCF that doula use for billing.

CPT Code & Modifier	CPT Code Description
99600 – HD	Perinatal Doula Support Visit
59400 – HD	Doula Support at Delivery HD – Vaginal Delivery
59514 - HD	Doula Support at Delivery HD -c-section
59612 - HD	Doula Support at Delivery HD -V-BAC
99199 - HD	Postpartum Doula Support-15 Minute Increment
99199 - HD - U8	Doula Incentive Payment for Obstetric Postpartum Visit 7 to 84 Days After Labor and Delivery

In addition, doulas follow the guidelines in the HSCSN Provider Manual to bill for services. The Provider Manual is available for download at HSC Health Care System Provider Manual. Starting on page 79.

Below are few tips for submitting claims to HSCSN (All Network Providers):

- Confirm Eligibility: Verify that the enrollee is active.
- Document Services: Maintain thorough documentation for each service provided, including visit details and type of support.
- Select Correct Codes and Modifiers: Use the designated billing codes with the appropriate modifier to indicate doula services provided.
- Complete the Claim Form: Enter all required enrollee, provider information, and billing elements.
- Submit Claim: File the claim electronically (or via paper) according to HSCSN's submission guidelines in the Provider Manual.

By adhering to these guidelines and utilizing the specified codes and modifiers, doula providers can ensure proper reimbursement for DC Medicaid covered services. For additional support on billing for services, providers may contact their assigned HSCSN Provider Relations representative for assistance at hscsn-provideraffair@hschealth.org.

Q82 Attachment 3

MedStar Family Choice – Protocols for Doula Reimbursement

- The Doula reimbursement is based on the [DHCF Transmittal 25-36 from 12/29/25](#) identifying payment rates, CPT codes, and Modifiers.
- MFC-DC participating Doulas receive standardized provider training which includes detailed claims submission training, including how to submit a CMS1500 claim through MFC-DC's Provider Portal.
- Each Doula has a designated Provider Relations Associate who provides personalized support.
- Mamatoto Village submits monthly invoices based on their contract with MFC-DC.

Q82 Attachment 4

Wellpoint – Protocols for Doula Reimbursement

Wellpoint DC is in the process of developing a doula-specific claims billing FAQ document. As part of that development, we intend to integrate relevant information from DHCF's forthcoming doula-specific FAQ document once it is finalized. This integration will enhance the clarity and utility of our billing instructions and support materials available through the Availity platform.

Currently, doulas are required to register on the Availity platform. This registration is essential for joining the network and accessing further resources. Registration can be completed by visiting Availity's website and following the prompts for new user registration. Once registered, doulas will need to obtain participation contracts with Wellpoint DC. This step involves completing necessary agreements and documentation to become an in-network provider. Doulas can log into their Availity accounts to access detailed, step-by-step instructions for submitting both initial claims and corrected claims.

85. Please share all MCO performance measures data that are related to maternal health, including perinatal mental health, in FY 2025 and FY 2026, to date.

a. For each measure, please provide data on how each MCO, including HSCSN, performed in FY 2025 and FY 2026, to date.

Response:

DHCF continues efforts to improve the health of pregnant people and babies. DHCF tracks MCP performance in the HEDIS Prenatal and Postpartum Care measures via the Maternal Health and Birth Outcome Focus Study conducted by DHCF’s independent External Quality Review Organization (EQRO), Qlarant. Measurement Years must be evaluated after complete submission and processing of claims. Providers are allowed a full year from the date of service to submit a claim. Our most current study managed care enrollees who were continuously enrolled for at least 120 days and had a live birth during fiscal year (FY) 2024, which spanned from October 1, 2023, through September 30, 2024. FY 2023 serves as a baseline; this report includes the second year of analysis and compares FY 2024’s performance to the FY 2023 baseline. These measures and the associated MCP performance are described below.

Prenatal and Postpartum Care (PPC)

The percentage of live births on or between October 8 of the prior year and October 7 of the measurement year.

For these enrollees, the measure assesses the following facets of prenatal and postpartum care:

- **Timeliness of Prenatal Care.** The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- **Postpartum Care.** The percentage of deliveries that had a postpartum visit on or between 7 to 84 days after delivery.

Table A.1 includes annual rates for the Prenatal and Postpartum Care measures. The DC Average is compared to national average benchmarks.

Table A.1. Prenatal and Postpartum Care Measures

Measure	Measurement Year (MY)	ACDC [AmeriHealth]	HSCSN	MFC [MedStar]	WPDC [Wellpoint/ formerly Amerigroup]	DC AVG	Comparison to Benchmark
Prenatal and Postpartum Care (PPC)							
Timeliness of Prenatal Care	2022	82.55%	66.67%	77.12%	NA	75.45%	♦
	2023	82.70%	70.00%	75.80%	NA	76.17%	♦
	2024	83.24%	61.54%	77.50%	75.18%	74.37%	♦
	2022	76.01%	78.57%	65.54%	NA	73.64%	♦
	2023	76.76%	53.33%	68.62%	NA	66.24%	♦

Postpartum Care	2024	78.38%	76.92%	73.33%	70.32%	74.74%	♦

* NA = MCP did not report due to contract start date of April 1, 2023.

♦ The DC MCP Average is below the National Average.

♦♦ The DC MCP Average is equal to or exceeds the National Average but does not meet the 75th Percentile.

♦♦♦ The DC MCP Average is equal to or exceeds the 75th Percentile.

Although the DC Average is below the national average, Table A.1 showed performance improvement;

- FY24: Timeliness of Prenatal Care
 - AmeriHealth and MedStar show improvements in Timeliness of Prenatal Care.
 - HSCSN's Timeliness of Prenatal Care performance declined.
 - Wellpoint established baseline performance data.
- FY24: Postpartum Care
 - AmeriHealth, HSCSN, and MedStar performance improved.
 - Wellpoint established baseline performance data.

In addition to prenatal and postpartum care, DHCF is tracking MCP performance in the *new* HEDIS Prenatal and Postpartum Depression Screening and Follow-Up measures. These measures and MCP performance are described below. For these *new* measures, it is important to note that not all MCPs are consistently reporting but are expected to moving forward.

Performance Measures:

Prenatal Depression Screening and Follow-Up (PND-E)

The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

- **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
- **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Postpartum Depression Screening and Follow-Up (PDS-E)

The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.

- **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.
- **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Table A.2 below includes annual rates for the Prenatal and Postpartum Depression Screening and Follow-Up measures. In FY 24, AmeriHealth is the only MCP that reported performance for all measures.

- The DC average and a comparison to benchmark was not calculated due to limited data.
- Comparison to benchmarks was not completed due to limited data.

Table A.2. Prenatal and Postpartum Depression Screening and Follow-Up Measures

Measure	Measurement Year (MY)	ACDC [AmeriHealth]	HSCSN	MFC [MedStar]	WPDC [Wellpoint/ formerly Amerigroup]	DC AVG	Comparison to Benchmark
Prenatal Depression Screening and Follow-Up (PND-E)							
Depression Screening	2022	51.32%	DNR	DNR	*	NC	-
	2023	54.34%	0.00%	DNR	*	NC	-
	2024	53.12%	0.00%	DNR	0.99%	NC	-
Follow-Up on Positive Screen	2022	45.63%	DNR	DNR	*	NC	-
	2023	40.40%	NA	DNR	*	NC	-
	2024	44.16%	NA	DNR	0.00%	NC	-
Postpartum Depression Screening and Follow-Up (PDS-E)							
Depression Screening	2022	32.72%	DNR	DNR	*	NC	-
	2023	46.09%	0.00%	DNR	*	NC	-
	2024	40.91%	0.00%	DNR	3.69%	NC	-
Follow-Up on Positive Screen	2022	40.98%	DNR	DNR	*	NC	-
	2023	46.00%	NA	DNR	*	NC	-
	2024	56.25%	NA	DNR	100%	NC	-

* MCP did not report due to contract start date of April 1, 2023.

NA – Not applicable. Screening not completed (0.00%); therefore, follow-up was not completed.

DNR – Did not report.

NC – Not calculated due to lack of MCP reporting.

86. Please provide updates on the implementation of A25-173—Expanding Access to Fertility Treatment Amendment Act of 2023, including data on how many beneficiaries accessed these services in FY 2025 and FY 2026, to date, broken down by type of service and total expenditures for each type of service.

a. Please send a link to where the DHCF report as required by A25-173 is posted.

Response:

On March 14, 2024, CMS approved [DC SPA #23-0016](#), which provides DHCF the authority to reimburse for select drugs when used to promote fertility. As indicated in [DHCF Transmittal 24-15 \(rev.\)](#), this coverage applies to the DC Healthcare Alliance program in addition to Medicaid. Utilization and expenditures are shown below for FY 2025 and FY 2026 to date.

DHCF Beneficiaries with Infertility Diagnosis and Use of Fertility Enhancing Drugs

Fiscal year	Type of service	Number of beneficiaries	Expenditures
FY 2025*	Drug services	31	\$1,964
FY 2026 to date	Drug services	9	\$440

Source: DHCF's Medicaid Management Information System data extracted January 12, 2025.

Note: Covered drugs include gonadotropin-releasing hormone antagonists. Because some of the drugs can be used for multiple indications (e.g., Parkinsons and certain cancers), the data above is restricted to beneficiaries with any history of an infertility diagnosis.

* Includes 5 beneficiaries enrolled in the Alliance, totaling \$101. All remaining data for FY 2025 and FY 2026 to date reflects Medicaid.

87. In FY 2024, DHCF announced that it will pause its plans to fully integrate behavioral health services into managed care. Does DHCF have an updated timeline to move forward the integration and whole-person care strategy for Medicaid beneficiaries?

Response:

DHCF and the Department of Behavioral Health (DBH) is reassessing carving in mental health rehabilitative and substance use disorder services into the managed care program. Currently, DHCF is analyzing the financial feasibility of the carve-in. Once preliminary information is received, DHCF and DBH will review and then make a recommendation to the Deputy Mayor for Health and Human Services.

88. For the local portion of the Medicaid Match for mental and behavioral health services under DBH's budget, please provide spending/costs and utilization data, both actual and projected, for FY 2025 and FY 2026, to date, and projected for the remainder of FY 2026.

Response:

DBH's Medicaid budget includes Medicaid utilization for Medicaid beneficiaries who are not Childless Adults. The Childless Adults were part of Medicaid expansion under the Affordable Care Act (ACA) and spending for this group is included in DCHF's budget because of enhanced federal match percentage. Budget expenditures for these services which occurred in FY 2025 were \$73,010,461.60, including \$4,770,887 funded from the non-lapsing local Medicaid HCBS Enhancement Fund at DHCF, and the total number of unique beneficiaries receiving these services was 18,210. Through the end of December 2025, spending for services which occurred in FY 2026 was \$12,304,409.96 (note that this figure is incomplete due to lagged submission and payment of claims and will be higher when run at a future date). The local budget for these services under DBH for FY2026 is \$44,502,648.

89. How many unique consumers were authorized for Mental Health Rehabilitation Services Community Support Services (CSS) in FY 2024, FY 2025, and FY 2026, to date?

Response:

The number of Medicaid beneficiaries with paid claims for Community Support Services billed by a Mental Health Rehabilitation Services provider are as follows: 35,282 in FY 2024; 37,174 in FY 2025; and 24,789 in the first quarter of FY 2026.

- a. Given that the District reduced the number of CSS units that each consumer can be authorized for during a 180-day period, how is DHCF ensuring consumers are directly notified of an impending reduction to their Medicaid services?**

Community Support Services providers are required to maintain treatment plans that document an individual's behavioral health needs and are expected to regularly communicate with beneficiaries on their service planning. In addition, the District communicates changes in program services to beneficiaries, providers, and other stakeholders through channels that include, for example: DHCF and DBH rulemakings that provide an opportunity for public notice and input; transmittals that summarize program changes for the public; billing manuals and trainings targeted to providers; and stakeholder meetings that seek to engage providers and others in the behavioral health services community.

91. Please provide details regarding all Psychiatric Residential Treatment Facility (PRTF) placements paid for with Medicaid funds in FY 2025 and FY 2026, to date. 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 other District agencies that were involved with each youth's case.

- a. Please share the provider rates for adolescent inpatient / residential treatment for mental health and substance use disorder.**

Response:

Table 1 below reflects the delivery system in which the Psychiatric Residential Treatment Facility (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 30 Medicaid beneficiaries placed at a PRTF in FY25.

Table 1. PRTF Beneficiaries Served FY25

Delivery Management System	Beneficiaries Served	Percent of Total
Fee-for-Service	11	36.66
AmeriHealth Caritas DC	8	26.66
Wellpoint (formerly Amerigroup)	2	6.67
HSCSN	5	16.66
OSSE	2	6.67
Local Dollars (CFSA)	1	3.34
Local Dollars (DYRS)	1	3.34
Total	30	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 most of the 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 is 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 FY25
Florida	6
Pennsylvania	2
Virginia	7
Maryland	14
Georgia	1
Total	30

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 FY25 was 5.1 months (approximately 156 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 (FFS) Medicaid. In June of FY21, a prior authorization requirement was put in place for PRTF care paid for by FFS Medicaid. The prior authorizations are approved by DHCF only if medical necessity has been confirmed by the DBH PRTF Placement Review Committee. This committee also reviews and makes determinations about the need for continued stays in PRTFs.

If the youth was recommended for placement by a sister agency (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 – Amerigroup, AmeriHealth Caritas DC, MedStar Family Choice, 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, to maximize the available resources to support monitoring HSCSN enrollees.

Table 3 (below) is based on information from DBH regarding the placement of youth in PRTFs by sister agencies. If the youth is affiliated with the Children and Family Services Agency (CFSA), the Department of Youth Rehabilitation Services (DYRS), or Court Social Services (CSS), DBH has primary responsibility for monitoring them.

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

Agency	Total # Beneficiaries FY 25	Other Agency Involvement
Child and Family Services (CFSA)	11	DBH, HSCSN, DYRS
District of Columbia Public School (DCPS)	0	DBH, HSCSN
Department of Youth Rehabilitation Services (DYRS)	17	DBH, HSCSN, CFSA
DC Superior Court (Court Social Services)	0	N/A
Office of the State Superintendent of Education (OSSE)	1	DBH, HSCSN
HSCSN	1	DBH
Total	30	

- a. Please share the provider rates for adolescent inpatient / residential treatment for mental health and substance use disorder.

Please see 91_Attachment.

Please note that the fee schedule for New Hope Carolinas, Inc., lists two rates. The second rate includes an enhancement for youth diagnosed with Autism Spectrum Disorder.



**DC FFS ACTIVE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES
CURRENT PER DIEM RATES AS OF 1/1/2026**

PID	NAME	ST	ORIGINAL ENROLLMENT DATE	CURRENT RATE	EFFECTIVE DATE	COMMENTS
019197300	DEVEREUX HOSP & CHILDRENT CTR	FL	07/01/91	\$689.47	01/01/26	
031456600	HARBOR POINT BEHAVIORAL HEALTH INC	VA	08/30/90	\$464.18	07/01/25	
032305400	GULF COAST YOUTH SERVICES DBA GULF COAST TREATMENT CENTER	FL	08/01/97	\$663.71	01/01/25	
036315800	NEW HOPE CAROLINAS, INC.	SC	09/04/03	\$525 \$788	07/01/24 07/01/24	
037056100	UHS OF SAVANNAH, LLC. (Formerly COASTAL HARBOR TREATMENT CENTER)	GA	09/30/05	\$649.22	07/01/24	
038678700	Keystone Continuum, LLC DBA Natchez Trace Youth Academy	TN	04/25/07	\$450.00	05/04/21	
056540700	WOODBOURNE CENTER, INC.	MD	06/01/15	\$862.79	10/01/25	
058363200	CORNELL ABRAXAS GROUP, INC	PA	01/08/16	\$537.47	01/01/24	
073390300	GRAFTON SCHOOL INC	VA	11/01/22	\$588.21	07/01/25	
077087822	11100 Billingsley Road OPCO, LLC DBA Recovery Centers of America at CAPI	MD	10/23/24			MCO Only

92. Please describe, if any, updated discussions that took place in FY 2025 or FY 2026 to-date regarding the Department's involvement in the District's pursuit of a local PRTF for psychiatric care for children.

Response:

None.

- 93. Please provide Medicaid billing data for the DBH School-Based Behavioral Health (SBBH) program from FY 2023, FY 2024, FY 2025, and FY 2026 to date. Include a breakdown for (1) DBH-employed clinicians and (2) Community-based Organization (CBO) clinicians, stratified by CBO group. For each group please provide:**
- a. Total Medicaid reimbursement amounts;**
 - b. Number of students served;**
 - c. Types of services billed (ex. individual therapy, group therapy, assessments).**

Response:

See Attachment 1 to Question 93.

Source: DHCF Medicaid Management Information (MMIS) data extracted 1/13/2026.

Notes: Reflects final paid fee-for-service (FFS) claims and managed care organization (MCO) encounters billed with a school place of service, a rendering provider NPI on a list of Community-based Organization (CBO) clinicians and DC Department of Behavioral Health (DBH) clinicians supplied by DBH, and one of the DHCF billing provider types specific to behavioral health noted below.

T01 = Mental Health Rehabilitation Services

T02 = Behavioral Health Stabilization

X02 = Mental Health Clinic (i.e., freestanding)

X04 = ASARS

X06 = ASTEP

X08 = Recovery Support Services

FY2023 Summary of Medicaid billing data for the DBH School-Based Behavioral Health (SBBH) program

		Total Medicaid Reimbursement			Number of Students Served		
		CBO Clinician	DBH-Employed Clinician	Total	CBO Clinician	DBH-Employed Clinician	Total
Totals*		\$735,831	\$275,537	\$1,011,368	393	101	494
Procedure Code	Procedure Code Description						
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	\$2,262	\$2,336	\$4,598	19	16	35
90832	Psychotherapy, 30 minutes with patient	\$1,794	\$7,530	\$9,325	19	27	46
90834	Psychotherapy, 45 minutes with patient	\$33,539	\$83,198	\$116,737	57	43	100
90837	Psychotherapy, 60 minutes with patient	\$13,274	\$181,088	\$194,362	30	45	75
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES		\$124	\$124		1	1
90846	Family psychotherapy (without the patient present), 50 minutes	\$266	\$863	\$1,129	5	3	8
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	\$344	\$398	\$742	3	3	6
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)	\$3,382	\$0	\$3,382	16	-	16
G9002	COORDINATED CARE FEE, MAINTENANCE RATE	\$14,858	\$0	\$14,858	4	-	4
H0002	BEHAVIORAL HEALTH SCREENING TO DETERMINE ELIGIBILITY FOR ADMISSION TO TREATMENT PROGRAM	\$259	\$0	\$259	3	-	3
H0004	BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES	\$31,910	\$0	\$31,910	101	-	101
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT, FACE-TO-FACE, PER 15 MINUTES	\$16,748	\$0	\$16,748	58	-	58
H0039	ASSERTIVE COMMUNITY TREATMENT, FACE-TO-FACE, PER 15 MINUTES	\$355	\$0	\$355	3	-	3
T1015	CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE	\$597,153	\$0	\$597,153	139	-	139
T1019	PERSONAL CARE SERVICES, PER 15 MIN NOT FOR AN INPATIENT OR RESIDENT OF A HOSPITAL NURSING FACILITY ,ICF/IDD OR IMD PART OF THTE INDIVIDUALIZED PLAN OF TREATMENT (CODE MAY NOT BE USED TO INDENTIFY SERVICES PROVIDED BY HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT	\$685	\$0	\$685	1	-	1
T1023	SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED PROGRAM, PROJECT OR TREATMENT PROTOCOL, PER ENCOUNTER	\$19,001	\$0	\$19,001	67		67

*Total Number of Students Served will not equal student counts by procedure code because an individual student can receive multiple services.

FY2024 Summary of Medicaid billing data for the DBH School-Based Behavioral Health (SBBH) program

		Total Medicaid Reimbursement			Number of Students Served		
		CBO Clinician	DBH-Employed Clinician	Total	CBO Clinician	DBH-Employed Clinician	Total
Totals*		\$1,379,380	\$224,185	\$1,603,564	982	186	1,166
Procedure Code	Procedure Code Description						
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	\$53,178	\$10,274	\$63,451	316	59	375
90832	Psychotherapy, 30 minutes with patient	\$38,832	\$52,056	\$90,888	156	95	251
90834	Psychotherapy, 45 minutes with patient	\$71,128	\$55,056	\$126,184	163	87	250
90837	Psychotherapy, 60 minutes with patient	\$235,282	\$87,578	\$322,860	246	46	292
90846	Family psychotherapy (without the patient present), 50 minutes	\$1,708	\$3,813	\$5,521	13	33	46
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	\$2,870	\$4,054	\$6,925	16	25	41
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY	\$67	\$0	\$67	1	-	1
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)	\$8,179	\$301	\$8,480	46	4	50
96127	BRIEF EMOTIONAL OR BEHAVIORAL ASSESSMENT	\$36	\$0	\$36	1	-	1
99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH MODERATE LEVEL OF DECISION MAKING, IF USING TIME, 30 MINUTES OR MORE	\$1,813	\$0	\$1,813	7	-	7
99215	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT WITH HIGH LEVEL OF MEDICAL DECISION MAKING, IF USING TIME, 40 MINUTES OR MORE	\$1,796	\$0	\$1,796	6	-	6
H0002	BEHAVIORAL HEALTH SCREENING TO DETERMINE ELIGIBILITY FOR ADMISSION TO TREATMENT PROGRAM	\$783	\$1,377	\$2,160	9	15	24
H0004	BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES	\$204,751	\$403	\$205,153	226	3	229
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT, FACE-TO-FACE, PER 15 MINUTES	\$65,881	\$6,185	\$72,066	404	46	450
H0039	ASSERTIVE COMMUNITY TREATMENT, FACE-TO-FACE, PER 15 MINUTES	\$1,188	\$0	\$1,188	4	-	4
H0040	ASSERTIVE COMMUNITY TREATMENT (ACT) - THIRTY (30) DAY BILLING PERIOD PAYMENT -	\$3,563	\$0	\$3,563	2	-	2
H2011	CRISIS INTERVENTION SERVICE, PER 15 MINUTES BILLED BY MENTAL HEALTH PROVIDERS. DO NOT OVERWRITE CODE.	\$239	\$0	\$239	3	-	3
H2022	COMMUNITY-BASED WRAP-AROUND SERVICES, PER 15 MINUTES	\$1,295	\$0	\$1,295	6	-	6
H2033	MULTISYSTEMIC THERAPY FOR JUVENILES, PER 15 MINUTES	\$166	\$0	\$166	1	-	1
T1015	CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE	\$674,674	\$0	\$674,674	196	-	196
T1017	TARGETED CASE MANAGEMENT, EACH 15 MINUTES	\$86	\$172	\$258	1	1	2
T1019	PERSONAL CARE SERVICES, PER 15 MIN NOT FOR AN INPATIENT OR RESIDENT OF A HOSPITAL NURSING FACILITY ,ICF/IDD OR IMD PART OF THTE INDIVIDUALIZED PLAN OF TREATMENT (CODE MAY NOT BE USED TO INDENTIFY SERVICES PROVIDED BY HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT	\$149	\$2,917	\$3,066	1	1	2
T1023	SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED PROGRAM, PROJECT OR TREATMENT PROTOCOL, PER ENCOUNTER	\$11,716	\$0	\$11,716	41	-	41

*Total Number of Students Served will not equal student counts by procedure code because an individual student can receive multiple services.

FY2025 Summary of Medicaid billing data for the DBH School-Based Behavioral Health (SBBH) program

		Total Medicaid Reimbursement			Number of Students Served		
		CBO Clinician	DBH-Employed Clinician	Total	CBO Clinician	DBH-Employed Clinician	Total
Totals*		\$1,050,930	\$145,571	\$1,196,501	804	72	876
Procedure Code	Procedure Code Description						
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	\$37,887	\$1,885	\$39,773	233	13	246
90832	Psychotherapy, 30 minutes with patient	\$26,532	\$4,860	\$31,391	98	21	119
90834	Psychotherapy, 45 minutes with patient	\$44,893	\$8,238	\$53,132	118	22	140
90837	Psychotherapy, 60 minutes with patient	\$241,159	\$42,227	\$283,386	177	22	199
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	\$1,938	\$0	\$1,938	9	-	9
90846	Family psychotherapy (without the patient present), 50 minutes	\$1,793	\$891	\$2,684	16	7	23
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	\$1,865	\$826	\$2,690	10	6	16
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)	\$2,229	\$0	\$2,229	25	-	25
96127	BRIEF EMOTIONAL OR BEHAVIORAL ASSESSMENT	\$993	\$0	\$993	40	-	40
H0004	BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES	\$41,282	\$0	\$41,282	55	-	55
H0023	BEHAVIORAL HEALTH OUTREACH SERVICE (PLANNED APPROACH TO REACH A TARGETED POPULATION)	\$2,593	\$0	\$2,593	8	-	8
H0025	BEHAVIORAL HEALTH PREVENTION EDUCATION SERVICE (DELIVERY OF SERVICES WITH TARGET POPULATION TO AFFECT KNOWLEDGE, ATTITUDE AND/OR BEHAVIOR)	\$89,714	\$0	\$89,714	89	-	89
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT, FACE-TO-FACE, PER 15 MINUTES	\$22,652	\$2,036	\$24,688	186	20	206
H0039	ASSERTIVE COMMUNITY TREATMENT, FACE-TO-FACE, PER 15 MINUTES	\$117,584	\$0	\$117,584	94	-	94
H0040	ASSERTIVE COMMUNITY TREATMENT (ACT) - THIRTY (30) DAY BILLING PERIOD	\$4,751	\$0	\$4,751	1	-	1
H2011	PAYMENT - CRISIS INTERVENTION SERVICE, PER 15 MINUTES BILLED BY MENTAL HEALTH PROVIDERS. DO NOT OVERWRITE CODE.	\$11,493	\$0	\$11,493	24	-	24
H2022	COMMUNITY-BASED WRAP-AROUND SERVICES, PER 15 MINUTES	\$9,030	\$0	\$9,030	7	-	7
H2033	MULTISYSTEMIC THERAPY FOR JUVENILES, PER 15 MINUTES	\$5,294	\$0	\$5,294	4	-	4
S9484	CRISIS INTERVENTION MENTAL HEALTH SERVICES, PER HOUR	\$4,776		\$4,776	8	-	8
T1015	CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE	\$378,741	\$0	\$378,741	112	-	112
T1017	TARGETED CASE MANAGEMENT, EACH 15 MINUTES	\$2,469	\$0	\$2,469	26	-	26
T1019	PERSONAL CARE SERVICES, PER 15 MIN NOT FOR AN INPATIENT OR RESIDENT OF A HOSPITAL NURSING FACILITY ,ICF/IDD OR IMD PART OF THTE INDIVIDUALIZED PLAN OF TREATMENT (CODE MAY NOT BE USED TO IDENTIFY SERVICES PROVIDED BY HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT		\$84,608	\$84,608		1	1
T1023	SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED PROGRAM, PROJECT OR TREATMENT PROTOCOL, PER ENCOUNTER	\$1,262	\$0	\$1,262	5	-	5

*Total Number of Students Served will not equal student counts by procedure code because an individual student can receive multiple services.

FY2026 to date (October through early January) Summary of Medicaid billing data for the DBH School-Based Behavioral Health (SBBH) program

		Total Medicaid Reimbursement			Number of Students Served		
		CBO Clinician	DBH-Employed Clinician	Total	CBO Clinician	DBH-Employed Clinician	Total
Totals*		\$137,827	\$5,387	\$143,215	156	9	165
Procedure Code	Procedure Code Description						
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	\$5,199	\$146	\$5,344	31	1	32
90832	Psychotherapy, 30 minutes with patient	\$2,980	\$0	\$2,980	16	-	16
90834	Psychotherapy, 45 minutes with patient	\$2,122	\$0	\$2,122	11	-	11
90837	Psychotherapy, 60 minutes with patient	\$46,627	\$5,242	\$51,868	65	8	73
90846	Family psychotherapy (without the patient present), 50 minutes	\$1,755	\$0	\$1,755	3	-	3
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	\$627	\$0	\$627	3	-	3
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)	\$62	\$0	\$62	2	-	2
96127	BRIEF EMOTIONAL OR BEHAVIORAL ASSESSMENT	\$161	\$0	\$161	5	-	5
H0004	BEHAVIORAL HEALTH COUNSELING AND THERAPY, PER 15 MINUTES	\$2,006	\$0	\$2,006	2	-	2
H0036	COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT, FACE-TO-FACE, PER 15 MINUTES	\$1,340	\$0	\$1,340	21	-	21
H0039	ASSERTIVE COMMUNITY TREATMENT, FACE-TO-FACE, PER 15 MINUTES	\$0	\$0	\$0	1	-	1
H2011	CRISIS INTERVENTION SERVICE, PER 15 MINUTES BILLED BY MENTAL HEALTH PROVIDERS. DO NOT OVERWRITE CODE.	\$3,598	\$0	\$3,598	10	-	10
T1015	CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE	\$70,549	\$0	\$70,549	42	-	42
T1017	TARGETED CASE MANAGEMENT, EACH 15 MINUTES	\$802	\$0	\$802	5	-	5

*Total Number of Students Served will not equal student counts by procedure code because an individual student can receive multiple services.

94. How many childless adults or parents/caretakers who were previously enrolled in DC Medicaid have been transitioned to a Healthy DC Plan as of 12/19/25?

- a. What is that percentage in terms of total potential eligible adults to be enrolled in a Healthy DC Plan?**

Response:

Based on DCAS data as of 11/29/2025, a total of 18,182 Medicaid childless adults and parent/caretaker relatives with incomes above 138% FPL were expected to transition to HBX eligibility effective 1/1/2026. Based on data in DHCF's MMIS as of December 21:

- 15,588 (86% of the November 29 total) had incomes in the Healthy DC Plan range (from 139%-200% FPL).
- 1,823 (10% of the November total) had incomes in the Qualified Health Plan (QHP) range (above 200% FPL).
- 771 (4% of the November total) had incomes below 139% FPL. This could occur, for example, if an individual reported a change in circumstance (e.g., job loss) after DCAS ran its list on November 29.

Based on HBX data as of January 8, there were 14,738 enrollees transitioned from Medicaid to the Healthy DC Plan.

95. How many childless adults or parents/caretaker who were enrolled in DC Medicaid between September 1, 2025, and December 2025, with income between 138% and 200% of FPL, have not yet enrolled in Healthy DC?

Response:

Please see response to question 94 for a breakout of the Medicaid childless adult and parent/caretaker relative population from 139%-200% FPL expected to transition to Healthy DC Plan eligibility effective 1/1/2026 and the number enrolled in the Healthy DC Plan.

96. How many people whose DC Medicaid was terminated on January 1, 2026, due to the new income eligibility rules were not transitioned to Healthy DC because their countable income was determined to be above 200% of FPL.

Response:

Please see response to question 94 for a breakout of the Medicaid childless adult and parent/caretaker relative population above 200% FPL expected to transition to Qualified Health Plan (QHP) eligibility.

97. Please describe the process for a BHP enrollee who become pregnant and qualifies for Medicaid coverage. Please include:

- a. Who the enrollee would need to inform;**
- b. What forms they may need to complete, and within what specified time frame;**
- c. Income requirements;**
- d. Services an enrollee can expect during the pregnancy and post-partum period including length of coverage;**
- e. How DHCF will notify the enrollee that their coverage is ending; and**
- f. What coverage is available to both the parent and their child after pregnancy-related Medicaid coverage ends.**

Response

BHP enrollees who become pregnant will qualify for Medicaid. Residents can report this change to their health plan or DCHBX. Residents can report their pregnancy to DCHBX through all available methods, such as the DC Health Link resident portal, phone, e-mail, or mail. Residents only need to report that they are pregnant, the expected due date (or date of conception), and expected number of babies. No additional verification of pregnancy or completion of forms is needed for updating BHP eligibility.

After reporting a change, BHP enrollees will receive outreach from a DCHBX case worker to answer any questions and ensure that next steps in the transition process to Medicaid are clear. DCHBX will process the change in eligibility and work with DHS/DHCF staff to establish Medicaid eligibility. Residents will be eligible for Medicaid if they meet the following requirements:

Medicaid Program

- Pregnant
- DC Resident
- US Citizen or eligible immigration status
- Meet income requirements (319% FPL)

Residents are entitled to all services covered under the Medicaid State Plan, including care related to the pregnancy, labor, and delivery and any complications that may occur during pregnancy, as well as post-partum care which begins on the date the pregnancy ends. Medicaid offers an additional twelve (12) months of post-partum care.

Once the birth is reported, the child will automatically enroll in Medicaid until their first birthday, at which time they will need to be redetermined for Medicaid eligibility.

Once coverage ends for the birthing parent, the resident will be redetermined for alternative coverage under Medicaid, BHP, or QHP. If the resident qualifies for additional Medicaid coverage, they will receive notice alerting them to a change in Medicaid eligibility. If the

resident does not qualify for further Medicaid coverage, they will receive a notice of adverse action for Medicaid, and the case will be transferred to DCHBX for enrollment in BHP/QHP.

**DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

General Question

- 98. What transportation programs administered by the Department for Hire Vehicles (DFHV), Department of Aging and Community Living (DACL), Department of Behavioral Health (DBH), or any other District agencies are currently reimbursed in whole or in part through Medicaid?**
- a) Please describe how DHCF coordinates with each agency to ensure transportation services are billed appropriately to Medicaid.**
 - b) For each agency, please provide a breakdown of Medicaid transportation by service type, including non-emergency medical transportation, paratransit services, and specialized transportation programs.**

Response:

Medicaid reimbursed transportation services are covered for emergency ambulance transportation and non-emergency medical transportation (NEMT). Currently, emergency transportation services are provided by the District Fire and Emergency Medical Services (FEMS) and reimbursed directly by Medicaid. DHCF contracts with a transportation broker to provider NEMT services for the Medicaid fee for service (FFS) program; the managed care plans have similar arrangements for NEMT services.

DFHV, DACL, and DBH are not current Medicaid providers for the purpose of providing Medicaid covered transportation services.

**DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

General Question

99. Please provide the following data for each Medicaid-reimbursed transportation program:

- a) How many unique Medicaid beneficiaries received transportation services in FY 2023, FY 2024, FY 2025, and FY 2026, to date?**
- b) How many total one-way trips and round trips were reimbursed by Medicaid in FY 2023, FY 2024, FY 2025, and FY 2026, to date? And, what was the average cost per trip?**
- c) Total Medicaid spend on transportation services in FY 2023, FY 2024, FY 2025, and FY 2026, to date?**

Response:

See chart below- This is data from the NEMT Transportation Broker for Question 99 A & B. This information reflects the average reimbursed cost per trip paid to transportation providers from our vendor, MTM.

	A	B	C	D	E
	WASHINGTON DC MEDICAID	FY 2023	FY 2024	FY 2025	FY 2026 through 1/04/2026
Unique Medicaid Beneficiaires		4,386	3,781	4,134	2,821
One Way - To Leg		102,549	76,532	73,761	45,895
One Way - From Leg		81,592	66,477	66,236	42,511
Total Number of One Way Trip Legs		184,141	143,009	139,997	88,406
Average Reimbursed Cost Per Trip		\$ 35.42	\$ 39.23	\$ 41.63	\$ 44.90
	WASHINGTON DC MEDICAID IDD	FY 2023	FY 2024	FY 2025	FY 2026 through 1/04/2026
Unique Medicaid Beneficiaires		496	514	459	428
One Way - To Leg		43,584	48,631	46,999	36,296
One Way - From Leg		40,839	46,031	45,675	35,537
Total Number of One Way Trip Legs		84,423	94,662	92,674	71,833
Average Reimbursed Cost Per Trip		\$ 25.98	\$ 29.72	\$ 32.15	\$ 35.25
	WASHINGTON DC MEDICAID MY HEALTH GPS	FY 2023	FY 2024	FY 2025	FY 2026 through 1/04/2026
Unique Medicaid Beneficiaires		153	167	188	116
One Way - To Leg		273	214	248	163
One Way - From Leg		180	131	160	133
Total Number of One Way Trip Legs		453	345	408	296
Average Reimbursed Cost Per Trip		\$ 23.32	\$ 17.60	\$ 17.74	\$ 20.05
	WASHINGTON DC MEDICAID NURSE TRIAGE	FY 2023	FY 2024	FY 2025	FY 2026 through 1/04/2026
Unique Medicaid Beneficiaires		295	313	252	156
One Way - To Leg		72	70	151	28
One Way - From Leg		5	19	129	4
Total Number of One Way Trip Legs		77	89	280	32
Average Reimbursed Cost Per Trip		\$ 12.97	\$ 15.88	\$ 21.41	\$ 18.48

See chart below for Medicaid and Non-Medicaid expenditures for FY 2023 through FY 2026 year-to-date:

Cost Center Description	FY 2023	FY 2024	FY 2025	FY 2026
Non-Emergency Medical Transportation	19,631,470.26	23,945,426.75	15,059,371.83	3,998,277.38
Non-Emergency Medical Transportation - CHIP	87,570.36	272,630.82	112,005.99	23,009.52
Fire & EMS Services (Ambulance)	74,645,416.80	85,507,840.88	90,126,350.87	8,759,850.58
Fire & EMS Services (Ambulance) - CHIP	489,714.41	683,748.57	859,654.02	141,097.43
OSSE-Children W/Special Needs Transportation	22,950,359.24	28,619,221.99	9,824,652.50	1,450,384.70
OSSE- Children W/Special Needs Transportation - CHIP	2,146,320.54	2,206,336.84	717,664.68	311,475.78
Alliance Emergency Medical Transportation	1,316,093.12	2,303,073.95	2,118,263.84	0.00

Other transportation spending not included above are transportation services that are within managed care capitation rates.

**DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

100. What performance metrics does DHCF use to monitor Medicaid-reimbursed transportation services (ex. on-time trips, trip completion rates, beneficiary complaints, etc.)?

Response:

DHCF's non-emergency medical transportation (NEMT) program uses a comprehensive set of performance metrics to monitor Medicaid-reimbursed transportation services and ensure beneficiaries have reliable, timely, and appropriate access to care. Our monitoring framework includes the following categories:

Access and Availability Metrics

- Denial rate of requested trips, which captures the percentage of trip requests that were not fulfilled.
- Trip fulfillment rate, measuring the percentage of requested trips that were successfully completed.
- Vehicle type availability, ensuring the fleet includes the appropriate vehicle types needed to meet beneficiary needs across all wards.

Timeliness and Reliability Metrics

- On-time pickup and drop-off performance, monitored through daily and monthly reporting.
- Late arrivals and driver no-show rates, supported by a dedicated report that tracks both beneficiary and driver no-show details, which DHCF reviews closely.

Quality of Service Metrics

- Complaint and grievance monitoring, reviewed monthly with the vendor. When repeated complaints emerge, DHCF intervenes immediately to require corrective action and prevent escalation.
- Surveys and audits, including desk audits conducted by the DPI team and on-site, pop-up audits conducted by the Contract Administrator.
- Annual vehicle inspections, attended by DHCF to ensure compliance with state and federal safety and regulatory requirements.

Compliance and Regulatory Metrics

- Monthly status and bi-monthly compliance meetings with the vendor, during which eligibility, prior authorizations, credentialing, and vehicle inspection results are reviewed in detail.
- Utilization and Efficiency Metrics
- Cost-effectiveness and operational efficiency monitoring, ensuring the program is delivering value while meeting beneficiary needs.

Network Adequacy Metrics

- Provider-to-beneficiary ratios,
- Backup provider coverage, and
- Peak-time capacity assessments,

All of which are evaluated by the broker to ensure the network can meet demand across all wards.

Health Outcome Metrics

- Missed appointment rates attributable to transportation,
- Hospital readmission correlations, and
- Dialysis attendance rates,

**DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

101. Please describe how DHCF assesses whether existing transportation is sufficient to meet beneficiary demand across wards.

Response:

DHCF's Non-Emergency Medical Transportation (NEMT) program assesses whether existing transportation services are sufficient to meet beneficiary demand across all wards through a comprehensive, data-driven approach. This includes analyzing the number of active beneficiaries by ward and by transportation mode, as well as reviewing key performance metrics and KPIs. DHCF uses transportation provider trip reports to evaluate capacity, fleet utilization, on time performance, and overall service delivery. In addition, DHCF's program integrity team conducts independent utilization analyses to further validate demand and service levels.

Once the program integrity team retrieves the data, they immediately provide it to the Contract Administrator (CA). The CA reviews the information and makes decisions on how to move forward to ensure the service is being fully utilized by the beneficiary population. This review helps determine whether adjustments, additional oversight, or targeted outreach are needed to meet demand across all wards.

Most recently, DHCF's vendor increased their marketing and outreach efforts, including collaboration with the Department of Human Services – Economic Security Administration (ESA) and participation in community events across the District. These efforts are designed to identify and engage eligible beneficiaries particularly those in wards with lower utilization to ensure they are aware of and able to access NEMT services.

DHCF also performs ongoing compliance monitoring through bi-monthly meetings with the transportation vendor. During these meetings, DHCF reviews trip activity, ride assignments across all wards, and any operational issues or barriers. These discussions help identify compliance concerns and opportunities to strengthen outreach and marketing efforts to ensure utilization rates align with District expectations.

To supplement the data review, the CA conducts in-person audits at adult day care facilities during both pick-up and drop-off times. These site visits allow DHCF to verify that the beneficiary population using the service aligns with reported data and to ensure that transportation services are adequately meeting the needs of beneficiaries in real time.

**DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

- 102. Please provide an update on 1115 waiver planning, including what the timeline is for implementation, and what funding considerations exist for implementing the waiver.**
- a) What housing support and services will be included in the District's 1115 waiver and how will it be implemented?**

Response:

In June 2024, DHCF submitted a [five-year renewal request](#) of the Behavioral Health Transformation 1115 Waiver to the Centers for Medicare & Medicaid Services (CMS). In this submission, DHCF proposed: (1) extending current waiver authorities (i.e., residential substance use disorder (SUD) and serious mental illness (SMI) treatment, and elimination of the \$1 copay for medication assisted treatment); and (2) implementing new justice-involved reentry and health-related social needs (HRSN) services. Since the 2024 submission, CMS provided temporary extensions of the current waiver authorities, allowing DHCF to continue reimbursing for these services while CMS considers our 1115 waiver renewal request. The current temporary extension expires on December 31, 2026.

Upon approval of the waiver, DHCF anticipates approximately a one-year planning period to ensure completion of required post-approval deliverables to CMS and allow for implementation readiness. Given the current budget environment, DHCF would prioritize locally funded programs. While the 1115 renewal application remains pending with CMS, DHCF has continued to move forward with planning and community engagement activities to support implementation, including:

- **Implementation and Policy Planning:** Since July 2024, DHCF leveraged the Medical Care Advisory Committee Health System Redesign (HSR) Subcommittee to support 1115 renewal policy and planning. These monthly meetings are well attended, with over 100 individuals regularly participating. The HSR group developed implementation-related recommendations across housing, reentry, and nutrition services. These recommendations and other feedback can be found on the DHCF [1115 waiver webpage](#).
 - **Enhanced Community Engagement:** In January 2025, DHCF launched an effort to get targeted feedback from beneficiaries, front-line staff; individuals who often are unable to attend the monthly HSR meetings. Feedback was received from over 130 Medicaid beneficiaries and frontline staff via surveys, listening sessions, and community meetings.
 - **Provider Readiness Trainings:** In July 2025, DHCF launched a seven-month [learning collaborative](#) to help providers and organizations that deliver or partner with housing, nutrition, and reentry services prepare for Medicaid payment and operations. Thirty-nine (39) organizations participated in learning collaborative activities including interactive webinars, individual and group coaching sessions, and an in-person half-day meeting.
- a. Housing Supports in the Pending 1115 Waiver Application: DHCF included the following housing supports in the 1115 waiver application, consistent with November 2023 CMS guidance:

- Rent/temporary housing for up to six (6) months and related utility assistance;
- Short-term pre-procedure and/or post-hospitalization housing for up to six (6) months;
- Transition, navigation, pre-tenancy, and tenancy-sustaining services;
- One-time transition and moving costs;
- Medically necessary home remediations; and
- Home/environmental accessibility modifications.

Also consistent with the November 2023 CMS guidance, DHCF's proposal targeted beneficiaries transitioning out of or experiencing the following situations:

- Institutional care or congregate settings such as nursing facilities, IMDs, intermediate care facilities, acute care hospitals, group homes, and correctional facilities
- Homelessness, risk of homelessness, or transitioning out of an Emergency Shelter
- Individuals transitioning out of the child welfare system including foster care

Of note, CMS has since rescinded the November 2023 guidance and is considering HRSN waivers on a case-by-case basis.

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103. How many unique individuals received the Housing Supportive Services (HSS) Medicaid 1915(i) State Plan benefit in FY 2025 and FY 2026 to date, broken down by housing related activity provided?

Response:

In FY25, 6,497 beneficiaries received Medicaid Housing Supportive Services (HSS) under the 1915(i) benefit. In FY26, 5,201 beneficiaries received HSS services. The chart below breaks out the housing related activity by the two services authorized under the 1915(i) benefit: housing navigation and housing stabilization.

	FY2025*	FY2026*
Total	6,497**	5,201**
Housing Navigation***	1,884	753
Housing Stabilization****	5,377	4,514

Source: DHCF MMIS data extracted 12/30/2025.

Notes:

*Reflects final status paid claims with a date of service in the fiscal years shown.

**Sum of rows can exceed unduplicated total due to individuals receiving both service types during the year.

****Housing Navigation*: Services that help a participant plan for, find, and move to housing of their own in the community. Identified in MMIS as the H2044 procedure code with U1 modifier.

*****Housing Stabilization*: Services that help a participant sustain living in their own housing in the community. Identified in MMIS as the H2044 procedure code with U2 modifier.

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Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Health Care Finance**

General Question

104. In FY 2024 Performance Oversight responses, DHCF stated they would not move forward with Community Health Workers (CHWs) without certification/license. What was DHCF's rationale for that decision?

a) How is DHCF considering the integration of CHWs in either its Transforming Maternal Health or 1115 waiver?

Response:

DHCF typically relies on DC Health certification/licensure and training requirements to establish provider qualification in Medicaid. This alignment between the agencies helps ensure Medicaid beneficiaries receive services from highly qualified providers while also adding an extra layer of provider oversight from DC Health.

- a. As we await DC Health's certification/licensure work, DHCF continues to review opportunities to integrate CHWs throughout its service array. Two specific initiatives that present opportunities for CHW integration are TMaH and the 1115 waiver.

In TMaH, coverage of perinatal CHWs is an optional element of the model. DHCF is awaiting additional information from CMS on what may be required as part of this optional element and how it may be integrated into the value-based payment model currently being designed by CMS. In the interim, DHCF has leveraged the Maternal Health Advisory Group to solicit policy and implementation feedback on maternal health innovation. Over the last year, providers, beneficiaries, and trade associations have met monthly at Maternal Health Advisory Group meeting to inform DHCF, including a meeting in December 2025 focused solely on doulas and perinatal CHWs. The notes from these meetings can be found here:
<https://dhcf.dc.gov/page/transforming-maternal-health>

Similarly, under the 1115 waiver, DHCF is awaiting CMS approval as outlined in the response to Question 102. In the interim, DHCF has leveraged the Health System Redesign (HSR) Subcommittee of the Medical Care Advisory Committee (MCAC) to solicit policy and implementation feedback on the 1115 waiver. Over the last 18 months, providers, beneficiaries, and trade associations have met monthly at the HSR meeting to inform DHCF, culminating in a set of recommendations. One recommendation received from the HSR was to: "Advance the policy changes required to allow community health workers (CHWs) to be a fully integrated workforce to support the provision of HRSN service delivery, within their appropriate scope and training. This will require implementation of certification standards by DC Health, recognition of CHWs as a qualified provider type by DHCF, and identification of covered services. If a systemic approach cannot occur due to funding or other constraints, the Subcommittee recommends DHCF and community stakeholders collaboratively determine if other avenues exist for enhanced integration of this workforce." The notes from these meetings can be found here:
<https://dhcf.dc.gov/1115-waiver-initiative>

105. Please provide the following information on access to care coordination in the District:

- 1. How does DHCF currently pay for care coordination?**
- 2. Does DHCF set standards, targets, or ratios for how many case managers per member each MCO employs?**

If so, please provide the standards and whether each MCO is meeting the requirements.

Response:

1. How does DHCF currently pay for care coordination?

DHCF's contracted Actuary includes administrative costs as part of capitation rate development, which anticipates the expected cost to operate a Medicaid managed care program. The model includes personnel costs for program management and general administrative operations, as well as non-personnel costs necessary to administer the program, including Case Management as defined by DHCF's contractual requirements.

The care management model includes both care management and care coordination to ensure efficient, coordinated, and quality care. Care coordination is mostly an administrative support, available to all beneficiaries, and often performed by a non-licensed staff member.

Case management is a team-based, person-centered approach, that seeks to effectively manage patients' medical, social, and behavioral conditions.

DC Healthy Families Program (DCHFP)

The rate modeling assumes 100% of beneficiaries will have access to care coordination, whereas case management will be focused on low- to high-needs beneficiaries, anticipated to be approximately 10% of the total program population. This projection assumes 100% of SSI Adults 21+ and 5% of other populations receive case management services. The care management modeling includes consideration for case management FTEs based on a beneficiary-to-staff ratio (see next response).

Year (DCHFP)	General Administration Expense	Care Management	Total
FY2025	\$31.59	\$20.15	\$51.74
FY2026	\$32.41	\$18.70	\$51.11

Child and Adolescent Supplemental Security Income Program (CASSIP)

The care management modeling assumes 100% of beneficiaries will have access to care management. Mercer stratified the CASSIP population as low- to specialized high-need members based on the tiers of care management described in the CASSIP contract. The modeling includes consideration for care management FTEs based on a beneficiary to staff

Ratio.

Year (CASSIP)	General Administration Expense	Care Management	Total
FY2025	\$330.69	\$291.25	\$621.93
FY2026	\$392.02	\$310.35	\$702.38

2. Does DHCF set standards, targets, or ratios for how many case managers per member each MCO employs? If so, please provide the standards and whether each MCO is meeting the requirements.

DHCF does not set staff-to-enrollee ratios for the DC Healthy Families Program (DCHFP). DHCF contractually requires the MCP to assign specified licensed healthcare professionals to enrollees depending on complexity.

For the Child and Adolescent Supplemental Security Income Program (CASSIP), the MCP is meeting the Case Manager-to-Enrollee acuity level ratio requirements, and are as follows:

- I. Acuity Level I (Low): 1:100
- II. Acuity Level II (Intermediate): 1: 75
- III. Acuity Level III (High): 1: 60.

117. How many grievances were filed against DHCF providers and DHCF during FY 2025? Please briefly describe the grievances filed and DHCF's response. How many of these grievances did DHCF find in favor of the beneficiary?

Response:

In FY25, a total of 97 administrative hearing requests were filed on behalf of consumers by the Office of Health Care and Public Benefits Ombudsman Bill of Rights (OHCPBOBR). Of the 97 administrative hearing requests that were filed, 53 (55%) were against the Department of Human Services (DHS). Of those 53 hearing requests, 45 (85%) were for inaction or delay in processing an application/recertification for medical benefits; 4 (7%) were for denial of application/recertification for medical benefits; 2 (4%) were for the denial of retro-active Medicaid benefits; and 2 (4%) were regarding the Supplemental Nutrition Assistance Program (SNAP) benefits (reduction and termination).

Of the 97 administrative hearing requests filed, 1 (1%) was filed against the Department on Disability Services (DDS) for the reduction of in-home support services.

Of the 97 administrative hearing requests filed, 43 (44%) were filed against the Department of Health Care Finance (DHCF). Of those 43 hearing requests, 20 (47%) were for inaction or delay in processing an application/recertification for Elderly and Persons with Disabilities (EPD) Waiver benefits; 5 (12%) were for denial or termination of PCA/Private Duty Nursing service hours (unmet or no LOC); 4 (9%) were termination/denial of benefits through the Katie Beckett Waiver (unmet or no LOC); 3 (7%) for denial of increase in PCA hours; 2 (5%) involved case management services (delay in assignment and termination-inability to meet client's needs); 2 (5%) for the denial of medical or dental services; 2 (5%) were for the reduction of PCA services; 1 (2%) denial of payment for nursing home stay; 1 (2%) was for the denial of EPD Waiver application (excess income); 1 (2%) was for non-payment of PCA services (Services My Way Program); 1(2%) was for failure to provide PCA Services; and 1 (2%) was for termination of benefits (program policy change).

Of the 43 DHCF administrative hearing requests filed, 13 (30%) were against United Health Care (UHC) Dual Eligible Special Needs Program (D-SNP). Of those 13 hearing requests, 13 (100%) were for inaction or delay in processing an application/recertification for medical benefits.

Of the 43 DHCF administrative hearing requests filed, 5 (12%) were against Telligen. Of those 5 hearing requests, 3 (60%) were for the denial of an increase in PCA service hours; 1 (20%) was

for the reduction of PCA services based on an assessment; and 1 (20%) was for the denial of PCA service based on assessment.

OHCPBOBR was able to determine that 87 (90%) of these hearing requests were resolved successfully in favor of the beneficiary, 7 (7%) were resolved in favor of the provider, 1 (1%) is still pending, and 2 (2%) could not be determined (DDS and DHS).

- a. Please provide a narrative text around the grievances submitted to the Health Care Ombudsman in FY 2025 and FY 2026, to date, that DHCF had a role in reviewing and steps taken to resolve those issues.**

Although hearing requests were not submitted for many issues, as they were promptly addressed, OHCPBOBR still continues to receive numerous complaints from United Healthcare D-SNP enrollees regarding several covered services, including transportation, dental, pharmacy, PCA care coordination, case management services, and access to providers.

OHCPBBRO works closely with DHCF, Long Term Care Administration (LTCA) to efficiently resolve these concerns, and this collaboration has contributed to a decrease in filed grievances and hearing requests. Case details are documented on LTCA's Electronic Provider Programmatic Report (EPPR), enabling effective tracking and identification of recurring issues.

Any concerns raised to OHCPBOBR by individuals enrolled in a Managed Care Plan (MCP) are handled by OHCPBBRO staff to the best of their abilities. Issues beyond the scope of OHCPBOBR are escalated to the designated points of contact (POC) for each plan. These POCs provide swift follow-up to the affected members and relay a thorough explanation of all actions taken on their end, and report back to OHCPBOBR. OHCPBOBR additionally collaborates with DHCF, Health Care Delivery Management Administration (HCDMA) to report and address trends that require attention and resolution.

118. Describe outreach efforts the Department undertook to promote the work of the Office of the Health Care Ombudsman and Bill of Rights and encouraged the public to utilize its services in FY 2025.

The Office of Health Care and Public Benefits Ombudsman and Bill of Rights (OHCPBOBR) partnered with the Department of Aging and Community Living (DACL), Ward 8 Clergy and Faith Leaders, District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS), the Mayor's Office of Latino Affairs, the Mayor's Office of African Affairs, and organizers of various health fairs throughout the District, both in-person and virtually.

In FY 2025, the team participated in 70 community events.

To meet growing demand, OHCPBOBR assigned additional staff to outreach activities due to an increase in requests from organizations across the District. Outreach efforts were tailored based on questions received, discussion topics, and the types of assistance provided during events.

While in the community, the team provides information about OHCPBOBR and assists District residents in verifying their Medicaid eligibility. This year, our office also produced two new brochures:

- Sickle Cell Disease Treatment Brochure

https://healthcareombudsman.dc.gov/sites/default/files/dc/sites/Office%20of%20Health%20Care%20Ombudsman%20and%20Bill%20of%20Rights/page_content/attachments/Sickle%20Cell%20Disease%20Brochure.pdf

- Crisis and Urgent Behavioral Health Services for Children and Youth Brochure

https://healthcareombudsman.dc.gov/sites/default/files/dc/sites/Office%20of%20Health%20Care%20Ombudsman%20and%20Bill%20of%20Rights/page_content/attachments/DHCF_Behavioral_Health_Brochure_2025.pdf

OHCPBOBR continued working directly with managed care organizations' outreach departments to provide education and information about its programs and the role OHCPBOBR plays in ensuring District residents have access to health care services and resources. Additionally, OHCPBOBR provided information at District Government Open Enrollment Fairs.